# EFFECT OF CHANGES IN CAPITAL ASSET OWNERSHIP ON MEDICARE COSTS

## HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

AND THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

## COMMITTEE ON WAYS AND MEANS
## HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

SECOND SESSION

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MARCH 21, 1984

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**Serial 98-70**

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Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

35-141 O WASHINGTON : 1984

H781-54

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# EFFECT OF CHANGES IN CAPITAL ASSET OWNERSHIP ON MEDICARE COSTS

WEDNESDAY, MARCH 21, 1984

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
SUBCOMMITTEE ON OVERSIGHT,
*Washington, D.C.*

The subcommittees met at 10 a.m, pursuant to notice, in room 1100, Longworth House Office Building, Hon. Andy Jacobs, Jr. (chairman of the Subcommittee on Health), and Hon. Charles B. Rangel (chairman of the Subcommittee on Oversight) presiding.

[The press releases announcing the hearing follow:]

[Press release of Friday, January 27, 1984]

HON. ANDY JACOBS, Jr. (D., IND.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, AND HON. CHARLES B. RANGEL (D., N.Y.), CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT, OF THE COMMITTEE ON WAYS AND MEANS, ANNOUNCE A HEARING ON THE EFFECT OF CHANGES IN OWNERSHIP ON MEDICARE COSTS

The Honorable Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Health and the Honorable Charles B. Rangel (D., N.Y.), Chairman of the Subcommittee on Oversight of the Committee on Ways and Means, U.S. House of Representatives, announced today their intention to hold a joint hearing to examine the impact of mergers and acquisitions on medicare program costs.

Under present law, medicare reimburses hospitals for a portion of their costs of capital, including depreciation, interest and rent. Payments are based on the "reasonable costs" incurred in using a capital asset—such as a hospital building—to provide services to medicare beneficiaries.

On December 22, 1983, the General Accounting Office (GAO) issued a report, requested by the Honorable Bill Gradison (R., Ohio), showing how medicare and medicaid capital payments to hospitals can be increased by a change in ownership of the hospital. Under current medicare rules, when the ownership of a hospital changes hands, the new owner is permitted to revalue the acquired asset to reflect the actual purchase price, thus giving the new owner a higher basis on which the asset can be depreciated. This may result in medicare paying for the asset a second time at a higher price.

Interest cost reimbursed by medicare also increases. If the buyer borrows money to pay for the asset, medicare will have to make increased payments for interest costs. This results from the larger outstanding debt and higher interest rates. GAO concluded that the costs in one audited hospital had risen by $26 per day for medicare and $31 per day for medicaid as a result of the increased capital costs allocated to the hospital.

The GAO report identified questionable accounting practices which would increase program costs and also focused on several areas where medicare capital payment rules need clarification. A lack of clear rules can result in medicare overpayments and inconsistent application of the rules by medicare intermediaries across the country. GAO has asked the Department of Health and Human Services (HHS) to clarify its rules in light of the GAO findings.

The Subcommittees intend to invite GAO, HHS and other interested parties to comment on medicare's current policies regarding valuation of assets and the need for clarification of rules in this area.

The hearing will also review steps taken by States in limiting capital reimbursement for facilities—including nursing homes and hospitals—where such facilities change ownership. Finally, the Subcommittees will ask for testimony on the extent to which provisions of the tax code increase health care costs by encouraging acquisition of assets. The Subcommittees anticipate holding the hearing in mid-March. The date of the hearing will be announced by press release as soon as it has been scheduled.

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[Press release of Wednesday, February 16, 1984]

HON. ANDY JACOBS, Jr. (D., IND.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, AND HON. CHARLES B. RANGEL (D., N.Y.), CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT, OF THE COMMITTEE ON WAYS AND MEANS, ANNOUNCE A DATE AND TIME FOR THE HEARING ON THE EFFECT OF CHANGES IN OWNERSHIP ON MEDICARE COSTS

The Honorable Andy Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Health and the Honorable Charles B. Rangel (D., N.Y.), Chairman of the Subcommittee on Oversight of the Committee on Ways and Means, U.S. House of Representatives, scheduled today the date and time for the hearing previously announced (press release #5) to examine the impact of mergers and acquisitions on medicare program costs. The hearing will begin at 10:00 a.m., Wednesday, March 21, in Room B-318 Rayburn House Office Building.

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[Press release of Wednesday, February 24, 1984]

HON. ANDY JACOBS, Jr. (D., IND.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, AND HON. CHARLES B. RANGEL (D., N.Y.), CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT, OF THE COMMITTEE ON WAYS AND MEANS, ANNOUNCE A CHANGE IN LOCATION FOR THE HEARING ON THE EFFECT OF CHANGES IN OWNERSHIP ON MEDICARE COSTS

The Honorable Andy Jacobs, Jr. (D. Ind.), Chairman of the Subcommittee on Health and the Honorable Charles B. Rangel (D., N.Y.), Chairman of the Subcommittee on Oversight of the Committee on Ways and Means, U.S. House of Representatives, today announced a change in location for the hearing previously announced (press release #6) to examine the impact of mergers and acquisitions on medicare program costs. The hearing will begin at 10:00 a.m., Wednesday, March 21, 1984, and will be held in the Committee's main hearing room, 1100 Longworth House Office Building.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six copies are required and may be submitted by the close of business Friday, April 6, 1984, to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Room 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Committee office before the hearing begins.

Chairman JACOBS. The subcommittees will come to order.

Our hearing today is quite simply the effect of changes of ownership on medicare costs, and more specifically referring to ownership, I believe, of hospitals.

Our first witness has been delayed, so I think we will begin with the second witness, Mr. Markus. Are you present, sir? If you will please come forward and identify yourself. I believe all the witnesses have been instructed that we are following the 5-minute rule, and I would like to assure you that the witnesses at the other end of the list will be very grateful to you if that rule is honored strictly. Mr. Markus.

## STATEMENT OF GLENN R. MARKUS, PRINCIPAL, HEALTH POLICY ALTERNATIVES, INC.

Mr. MARKUS. Thank you, Mr. Chairman, members of the Subcommittees on Health and Oversight. My name is Glenn R. Markus. I am a principal with Health Policy Alternatives, a private Washington-based consulting firm specializing in the health care financing area.

The purpose of my testimony is to review briefly the policies that have been developed for the medicare program to establish the value of depreciable capital assets following their disposition through sale. I have also been asked to identify and briefly discuss some of those issues that have arisen in recent years about the appropriateness and validity of the Government's policies regarding revaluation of assets under medicare and effects that these policies have on program costs.

Many of these details, Mr. Chairman, are outlined in my statement, and I would ask that they simply be included in the record.

Chairman JACOBS. Without objection.

Mr. MARKUS. Mr. Chairman, present law provides that certain capital-related costs incurred by participating providers of services such as hospitals and nursing homes are reimbursable on a reasonable cost basis. These capital costs are excluded from the new prospective payment system for inpatient hospital services until October 1, 1986.

You are expected to receive a study later on this year by the Department of Health and Human Services looking at methods and proposals under which capital costs could be included in the prospective payment system.

Current regulations define which capital costs the Secretary of Health and Human Services recognizes as allowable for medicare purposes. The major elements of capital cost currently reimbursed under medicare include depreciation, interest expense, and in the case of proprietary or for-profit entities a return on owner or equity capital.

Under medicare, depreciation is based upon historical costs incurred by the present owner—I emphasize the present owner—in acquiring those assets. Special rules require that for depreciable assets acquired after July 1970, historical costs cannot exceed the lesser of the current reproduction costs adjusted for straight line depreciation over the life of the asset to the time of purchase or the fair market value at the time of purchase.

Also since 1970 proration of historical cost of an asset under medicare is generally allowed only on a straight line basis. Incidentally, Mr. Chairman, the accelerated cost recovery provisions adopted by Congress in 1981 to stimulate capital investment by permitting accelerated writeoff of assets for income tax purposes do not apply to medicare.

From the beginning of the program, program officials have had to devise policies to deal with the value of assets for which depreciation is allowed which are financed through borrowing or can be part of the base against which a return on equity capital is calculated following their disposition through sale. Like other businesses, health care facilities buy and sell various capital assets. Rules

are needed for sellers insofar as adjustments may be required in connection with depreciation already paid on assets sold. This is because previously allowed depreciation may have been found to be incorrect. Rules are also needed for buyers if those new buyers are also entitled to depreciation, interest expense, or return on equity payments in connection with newly acquired assets. Present regulations allow for the revaluation of the cost basis of medicare depreciable assets of a provider purchased in a bona fide sale.

In addition to being the basis for depreciation of the new owner of the purchased assets, the revalued cost basis is also generally used to compute the amount of gain to the seller, and as noted above, a revalued cost basis can also impact program costs in two other ways.

First, the revalued basis is the figure from which the return on equity capital is calculated, and second, the revised basis is also the figure from which the amount of medicare allowed reimbursible interest expenses is determined. That is, not all interest is otherwise allowed.

Following the passage of medicare in 1965, Mr. Chairman, program managers adopted revaluation policies designed to serve a number of broad objectives. First, that such policies should be neutral in their effects on transactions. That is, medicare's rules should neither encourage nor discourage the sale or acquisition of assets by participating providers.

Second, that the revaluation should be allowed only in the case of tangible assets changing ownership. Goodwill or the earning power value of assets would not be recognized in determining the value of such assets following sale.

To assure that the Government does not pay artificially inflated changes in the basis cost of assets by sale, specific tests of the reasonableness of transactions are now included in the regulations.

Under these rules, the cost basis for depreciable assets of a hospital or other provider acquired on or after August 1, 1970, through the purchase of an ongoing operation is limited to the lesser of the total price paid for the facility, total fair market value, combined fair market value test, or the current reproduction cost of the depreciable assets depreciated on a straight line basis over the life of the assets to the time of the sale.

Gains and losses realized from such sales are includable in allowable costs as an adjustment to depreciation claimed by a provider. The regulations provide that the amount of gain included in the determination of allowable cost is limited to the amount of depreciation previously claimed.

In other words, Mr. Chairman, medicare shares in any increases in the value of assets following sale if recognized under one of the tests described above by recapturing from the sale a portion of previously paid depreciation. At the same time, however, the cost basis of the assets sold to the new owner if that new owner is also entitled to capital payments on a cost basis recognized by medicare are stepped up or increased. Medicare will make payments for depreciation, and if appropriate, for interest expense and a return on equity payment for the remaining undepreciated life of the assets acquired at a higher cost basis.

The study conducted by the General Accounting Office relating to the cost impact of a large hospital organization acquisition, about which you will hear more later on this morning, raises in my mind two very broad and somewhat different considerations about medicare's present asset revaluation policies.

The first of these is whether these policies, and more importantly, whether their application by the Health Care Financing Administration, effectively serve the purposes for which they were originally adopted; namely, do they in fact protect the medicare program, which still elects to pay on the basis of cost for capital, from artificially inflated changes in asset values due solely to changes in ownership?

My own reading of the GAO report leads me to conclude that most of the estimated increased costs allocated to medicare because of the Hospital Corporation of America acquisition are in fact the result of differences about the interpretation and application of existing rules specifically designed to protect the medicare program against unwarranted increases in recognized asset values following a sale.

A second consideration, Mr. Chairman, is whether or not the Government ought to recognize any asset revaluation following a sale in the first place. Some argue that if no demonstrable or measurable benefit flows to the medicare program by allowing revaluations, and that instead overall program costs may actually rise because of such policies, medicare should not permit any stepup in asset values solely because of changes in ownership.

Some advocates of this view believe that medicare should never recognize more than net book value of assets acquired through sale, that is, historical cost of assets when first used under the program, minus any accumulated depreciation.

One of the effects of such a change in medicare policy would probably mean that the assets would not change hands unless sellers were willing to take less than the actual value of the assets in current dollars or buyers were willing to pay more in current dollars than they expected to recover in depreciation payments. Put another way, the prices at which future asset sales might occur would probably be lower than they would otherwise be if revaluation of assets continues to be medicare's policy. Potential sellers would thus be more reluctant to sell even if the buyer might be able to put the assets to more effective use, and buyers would more often achieve more favorable results from purchase or construction of new assets than from purchase of used property.

Now, whether or not changes ought to be made in medicare's policies governing asset valuations, it seems to me, depends upon the members' views about some of the following issues.

First, if Congress intends that the capital expenses of providers should continue to be reimbursed on a cost basis, if only until such time as it has an opportunity to study prospective payment opportunities for capital, then should payment for acquired assets be made on the basis of current values, namely, what it would cost to buy or replace these assets today, or on the basis of values established at some earlier point in time?

Moreover, if revaluation is still to be permitted, should more resources be invested by the Government to assure compliance with its present policies in this area?

Second, if Congress elects to change the present rules relating to revaluation, should such changes be made singularly or as part of some broader set of changes in capital payment policies under medicare?

Third, if changes are made in medicare's revaluation policies, what should be the purpose of those changes? As I have noted above, refusal to recognize any stepup in basis cost would probably have a depressing effect on the prices at which sales may occur. It seems doubtful, however, that such changes alone would bring sales or acquisition activity to a halt. Many other considerations other than medicare's revaluation policies shape business decisions to acquire existing assets.

Fourth, should medicare policies seek to encourage or to discourage the sale of tangible assets, and if so, to what end? The health care industry, in response to growing competitive pressures, is rapidly moving toward a restructuring and integration of its resources used to provide health care services. Would changes in medicare's rules promote or retard these developments?

And finally, Mr. Chairman, if Congress at some point decides to fold medicare's capital payments into the prospective payment system and permits increases in those payments in recognition of the effects of inflation on the future cost of health resources, including capital, then Congress will have to focus much more broadly on the revaluation issue than it seems likely to do at this time.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF GLENN R. MARKUS, PRINCIPAL, HEALTH POLICY ALTERNATIVES, INC.

Mr. Chairmen and Members of the Subcommittees on Health and on Oversight, my name is Glenn R. Markus. I am a principal with Health Policy Alternatives, a private Washington-based consulting firm that specializes in health care financing and related policy fields.

The purpose of my testimony is to review briefly the policies that have been developed for the Medicare program to establish the value of depreciable capital assets following their disposition through sale. I have also been asked to identify and briefly discuss some of the issues that have arisen in recent years about the appropriateness and validity of the Government's policies regarding revaluation of assets under Medicare and the effects of these policies on program costs.

MEDICARE'S CAPITAL ASSET PAYMENT POLICIES

Mr. Chairmen, present law provides that certain capital-related costs incurred by participating providers of covered Medicare services—such as hospitals or skilled nursing facilities—are reimbursable on a "reasonable cost" basis. Their capital costs are excluded from the new prospective payment system for inpatient hospital services until October 1, 1986. The Social Security Amendments of 1983 (P.L. 98-21) directs the Secretary of Health and Human Services to study and report to Congress later this year on methods and proposals under which capital costs may be included in the prospective payment system.

Current regulations define which capital costs the Secretary of Health and Human Services recognizes as allowable for Medicare payment purposes. Such costs must be reasonable and related to the provision of patient care. Reasonable costs include all necessary and proper expenses incurred in rendering covered services to beneficiaries. To be allowed, costs cannot exceed what a prudent and cost-conscious buyer would pay for a given item or service.

Under Medicare, the capital costs of participating providers are apportioned, or divided, between program beneficiaries and other patients using the facilities. This

is accomplished through accounting methods that attempt to measure the use of a facility's resources by Medicare patients relative to the total use of those resources by all patients. Once determined, these amounts are paid to facilities in addition to any amounts to which they may be entitled under the prospective payment system. For institutions not included in that system, capital costs are included in the amounts otherwise reimbursable on a cost-related basis.

The major elements of capital cost currently reimbursable under Medicare include depreciation, interest expense and, in the case of proprietary (or for-profit) entities, a return on equity (or owner capital). Depreciation expenses, of course, are amounts that represent the portion of an asset's cost that is charged to a particular period of operation, such as an accounting year. Depreciation is calculated through a system which prorates the cost or other basic value of tangible assets (less salvage value, if any) over the "useful lives" of such assets. The actual amount of depreciation recognized for any particular period depends on: the depreciation base, the "useful lives" of the assets in question, and the depreciation methods used to make the calculations.

Under Medicare, depreciation is based on the "historical cost" incurred by the *present* owner in acquiring the assets. Special rules require that for depreciable assets acquired after July 31, 1970, historical cost cannot exceed the lower of current reproduction cost, adjusted for straight-line depreciation over the life of the asset to the time of purchase, or the fair-market value at the time of purchase.

In general, the estimated useful lives developed by the American Hospital Association (AHA) are used by hospitals, and accepted by Medicare, for calculating depreciation payments. For assets acquired after 1981, use is made of the AHA's Estimated Useful Lives of Depreciable Assets (1978 edition) as a guide for such purposes. The AHA's 1973 Chart of Accounts for Hospitals is used for earlier acquired assets.

Since August 1, 1970, proration of the historical cost of an asset under the Medicare program is generally allowed only on a straight-line basis. Under this method, the historical cost of an asset (minus any estimated salvage value) is recovered by the provider in equal amounts over the useful life of the asset.

Incidentally, Mr. Chairmen, the accelerated cost recovery provisions adopted by Congress in 1981 to stimulate capital investment by permitting accelerated write-off of assets for income tax purposes do not apply to Medicare. Sec. 230 of the Economic Recovery Tax Act of 1981 (ERTA) indicated that the Secretary of Health and Human Services is "not required to apply any of the provisions of the Internal Revenue Code of 1954, as amended, in calculating depreciation (for the purposes of determining any cost under a program administered by the Secretary), unless a provision of law requires so expressly." In December, 1982, Medicare program officials announced that Medicare's reimbursement rules would not be modified to make them consistent with the accelerated cost recovery system recognized by the Internal Revenue Service for tax purposes.

### MEDICARE'S REVALUATION POLICIES

From the beginning of medicare, program officials have also had to devise policies to deal with the value of assets—for which depreciation is allowed, which are financed through borrowing or which can be part of the base against which a return on equity capital is calculated—following their disposition through sale. Like other businesses, health care facilities buy and sell various capital assets. Rules are needed for sellers, insofar as adjustments may be required in connection with depreciation already paid on assets sold. This is because previously allowed depreciation may have been found to be incorrect. rules are also needed for buyers, if the new owners also are entitled to depreciation, interest expense or return on equity in connection with newly acquired assets. Present regulations allow for revaluation of the cost basis of Medicare depreciable assets of a provider purchased in a *bona fide* sale. In addition to being the basis of depreciation for the new owner of the purchased assets, the revlaued cost basis is also generally used to compute the amount of gain to the seller. And, as noted above, a revalued cost basis can also impact program costs in two other ways. First, the revalued basis is the figure from which return on equity (ROE) capital is calculated. Second, the revised basis is also the figure from which the amount of Medicare allowed reimbursable interest expenses are determined—i.e., not all interest is allowed. Only interest on debt incurred to pay for tangible assets used to render patient care at Medicare's permitted price for the assets is allowed.

For example, Mr. Chairmen, consider a facility which had an original (or historical) cost to an owner of $1 million and a useful life of, say for illustration purposes, 10 years. At the end of the second year, the owner will have been entitled, on a

straight-line basis, to depreciation of $200,000. Assume further that the facility is sold at this time to a buyer for $1.2 million and that the transaction is financed by a combination of borrowed funds of $900,000 and equity capital of $300,000. Finally, assume that $100,000 of the purchase price is determined to be goodwill. Under these circumstances, the original owner actually had no depreciation costs because it would cost more to buy the assets, even though used for two years, than they originally cost. Thus, the previously paid depreciation should be recovered from the seller. The new owner has a depreciation base of $1.1 million and can be credited with interest costs on borrowing of 11/12 of $900,000 and ROE on 11/12 of $300,000.

Following passage of Medicare in 1965, program managers adopted revaluation policies designed to serve a number of broad objectives. First, that such policies should be neutral in their effects on transactions—that is, Medicare's rules should neither encourage nor discourage the sale or acquisition of assets by participating providers. Second, that revaluation should be allowed only in the case of tangible assets changing ownership. Goodwill, or the earning power value of assets, would not be recognized in determining the value of such assets following sale. Goodwill, it was argued, does not contribute to the production of Medicare patient care services.

To assure that the Government would not pay artificially inflated changes in the basis cost of assets by sale, specific tests of the reasonableness of transactions were also spelled out and are now part of the present regulations. Under these rules, the cost basis for depreciable assets of a hospital or other provider acquired on or after August 1, 1970, through purchase as an ongoing operation, is limited to the lowest of the following:

The total price paid for a facility by a purchaser, as allocated to individual assets; the total fair market value of a facility at the time of sale; the combined fair market value of individually identified assets at the time of sale; or, the current reproduction cost of the depreciable assets depreciated on a straight-line basis over the life of the assets to the time of sale.

Gains and losses realized from such sales are includable in allowable cost as an adjustment to depreciation claimed by a provider. The regulations provide that the amount of gain included in the determination of allowable cost is limited to the amount of depreciation previously claimed in Medicare allowed capital costs. The amount of a loss is limited to the undepreciated basis of the asset permitted under the program. In other words, Medicare shares in any increases in the value of assets following sale—if recognized under one of the tests described above—by recapturing from the seller a portion of previously paid depreciation. At the same time, however, the cost basis of the assets sold to the new owner (if that owner is also entitled to capital payments on a cost basis) recognized by Medicare are also "stepped-up" or increased. Medicare will make payments (for depreciation and, if appropriate, perhaps for interest costs and a return on equity as well) for the remaining undepreciated life of the acquired assets at a higher basis cost.

The study conducted by the General Accounting Office relating to the cost impact of a large hospital organization acquisition, about which you will hear more later on this morning, raises, in my mind, two broad and somewhat different considerations about Medicare's present assest revaluation policies. The first of these is whether the policies—and more importantly, whether their application by the Health Care Financing Administration—effectively serve the purposes for which they were adopted? Namely, do they in fact protect the Medicare program (which still elects to pay for capital on a *cost-basis*) from artificially inflated changes in asset values due solely to changes in ownership. My own reading of the GAO report leads me to conclude that most of the estimated increased costs allocated to Medicare because of the Hospital Corporation of America acquisition are, in fact, the result of differences about the interpretation and application of the existing rules specifically designed to protect the program against unwarranted increases in recognized asset values following a sale.

A second consideration, Messrs. Chairmen, is whether the Government ought to recognize any asset revaluation following a sale in the first place. Some argue that, if no demonstrable or measurable benefit flows to the Medicare program by allowing revaluations—and that, instead, overall program costs may actually rise because of such policies—Medicare should not permit any step-up in asset values solely because of changes in ownership. Some advocates of this view believe that Medicare should never recognize more than the net "book value" of assets acquired through sale—that is, historical cost of assets when first used under Medicare, minus any accumulated depreciation. One of the effects of such a change in Medicare policy would probably mean that assets would not change hands, unless sellers were willing to take less than the actual value of the assets in current dollars or buyers were willing to pay more in current dollars than they expected to recover in depreciation

payments. Put another way, the prices at which future asset sales might occur would be lower than they would otherwise be, if revaluation of assets continues to be allowed. Potential sellers would, thus, be more reluctant to sell, even if the buyer might be able to put the asset to more effective use, and buyers would more often achieve more favorable results from purchase or construction of new assets than from purchase of used property.

ISSUES

Whether or not changes should be made in Medicare's policies governing asset valuation following sale depends, I believe, on the Member's views about some of the following issues:

1. If Congress intends that the capital expenses of providers should continue to be reimbursed on a cost basis—if only until it has time to consider how to treat capital under prospective payment in general—then should payment for acquired assets be made on the basis of current values (what it will cost to buy or replace these assets today) or on the basis of values established at some earlier point in time? If revaluation is still permitted, should more resources be invested by Government to assure compliance with its policies in this area?

2. If Congress elects to change the present rules relating to revaluation, should such changes be made singularly, or as part of some broader set of changes in capital payment policies under Medicare?

3. If changes are made in Medicare's revaluation policies, what should be the purpose of such changes? As noted above, refusal to recognize any step-up in basis cost would probably have a depressant effect on the prices at which sales might occur. It seems doubtful, however, that such changes alone would bring sales or acquisition activity to a halt. Many considerations other than Medicare's asset revaluation policies shape business decisions to acquire existing assets.

4. Should Medicare policies seek to encourage or discourage the sale of tangible assets and, if so, to what end? The health-care industry, in response to growing competitive pressures, is rapidly moving toward a restructuring and integration of resources used to provide health care. Would changes in Medicare's rules promote or retard these developments?

5. Finally, if Congress, at some point, decides to fold Medicare's capital payments into the prospective payment system, and permits increases in those payments in recognition of the effects of inflation on the future costs of health resources (including capital), Congress will have to focus much more broadly on the revaluation issue than it is likely to do at this time.

Chairman JACOBS. Thank you very much, Mr. Markus, for your contribution to the record. I think you can be excused now.

Mr. MARKUS. Thank you.

Chairman JACOBS. Our colleague, Willis Gradison, will testify now, and let the record show that at the invitation of the Chair, Mr. Gradison will participate subsequent to his testimony as an ex officio member of the subcommittee. Mr. Gradison.

## STATEMENT OF HON. BILL GRADISON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. GRADISON. Thank you, Mr. Chairman.

I appreciate the opportunity you have provided in holding this hearing to examine the impact of mergers and acquistions on medicare program costs. I am particularly pleased that both the Subcommittee on Health as well as the Subcommittee on Oversight have taken an interest in this important area of concern which not only affects the cost of our federally financed health care programs, but the cost of health care for all Americans.

I want to particularly recognize the outstanding and professional work of the General Accounting Office in dealing with this very complex medicare payment issue. I believe that the GAO report stands on its own merits, and for the sake of time I will refrain

from a detailed account of their findings. You will, of course, be hearing from GAO very shortly.

Mr. Chairman, the report documents the unfairness of higher and higher medicare and medicaid payments to those who traffic in hospitals compared to those who do not. It provides convincing evidence of the wastefulness and folly of continuing a payment method which allows hospital sales at higher and higher prices and helps to finance the sales through increased medicare and medicaid payments. Medicare's policy when coupled with the accelerated cost recovery provisions in the Tax Code serve to provide an incentive to buy and sell hospitals.

According to the Congressional Budget Office, acquisitions will add another $830 million in new costs to the medicare and medicaid program over the next 5 fiscal years.

While some industry experts believe that this amount is overstated, we do note that significant cost increases can and do occur as a result of acquisitions. The case study I requested in April 1982 from GAO and which culminated in their recent report confirms the very real nature of this concern.

At a time when solvency of the medicare trust fund is of paramount concern to the country, few medicare payment practices are so glaringly wasteful and expensive as the subsidies provided in the buying and selling of hospitals. These include reimbursement of depreciation of hospital assets as well as the interest on money borrowed for purchase. Intended originally as a fair way to pay hospital costs, this medicare policy has turned into a loophole and an abuse of substantial financial consequence. The impact of sales is also substantial on all third party payors, and ultimately on the purchaser of health care services and insurance.

The Federal Government, through the medicare program, heavily supports hospitals through guaranteed payment for the elderly. The two principal subsidies provided are the depreciation medicare pays on hospital assets and the interest it pays on the money borrowed to purchase those assets. When existing hospitals are sold, medicare increases these payments to reflect the newly established value of the old assets, and eliminates much of the risk of the buyer through its guaranteed payments, and if that were not enough, Mr. Chairman, medicare will actually reimburse both the buyer and the seller for the incurred acquisition costs. This includes such items as legal fees, accounting costs, and the administrative cost of negotiating and completing the transaction. In addition, medicare will make payment to the buyer to reflect increases in net ownership equity resulting from the acquisition.

The economic effect of these medicare reimbursement rules is certainly not to discourage the buying and selling of hospitals. In the last few years, the number of hospital sales has increased dramatically. We now see phenomena unheard of when the medicare rules were established, such as the accumulation and sale of large blocks of hospitals and the advertising of hospitals in national circulation newspapers as if they were any other hot commodity.

On August 4 of last year, one 512-bed Florida hospital fully operating and county owned was prominently pictured in a Wall Street Journal ad soliciting bids for its purchase. Because medicare and

other payors will pay back to the buyer virtually any price that he pays for a hospital, bidding for hospitals has been aggressive.

It is this phenomenon, the absence of any effective marketplace restraint, and the ability of an owner to obtain ever higher Government and insurance company payments by buying and selling health facilities that drove New York State several years ago to outlaw upward revaluations of hospitals upon their sale. I understand that we will be hearing later from Mr. Morton Hyman of New York State on the details of the action of that state.

Mr. Chairman, when I first released the GAO report, I indicated that I was considering remedial legislation to address this concern. I chose the word "remedial" because I believe we need to get out of the business of allowing capital costs to be reimbursed on a cost basis as currently provided under the new prospective payment system. While the Congress set a target date of October 1, 1986, to bring capital costs into the system, it appears that we should take some interim steps.

As you may know, the Finance Committee in the other body recently approved an interim approach that would limit effective October 1, 1984, the amount of capital related costs, that is, depreciation, interest, and return on equity, a new owner can claim under the medicare program for reimbursement purposes. Specifically, the Finance Committee proposal would allow depreciation payments to the new owner on the basis of the depreciated book value of the asset as shown on the seller's books of accounts. The new owner would also be held to the seller's old depreciation schedule. With respect to interest and return on equity, payment would be based on the seller's original book value before depreciation.

I believe that the Finance Committee action is a reasonable interim way to deal with this concern. Accordingly, I plan to introduce shortly similar legislation with at least one modification. To avoid any sudden flurry of acquisition activity in trying to beat the October 1, 1984, effective date in the Finance Committee proposal, I would propose that the legislation apply to transactions after April 20, 1983, the date after which Congress placed the industry on notice that capital related costs may be treated differently.

In addition, I am considering two additional provisions, but would like to discuss them with GAO later in the hearing. First of all, there appears to be a potential loophole for circumventing the limitations that would be established under the interim legislation. This pertains to sale and leaseback and other lease or rental arrangements. For example, hospitals could possibly avoid the limitations by leasing or renting their facilities rather than purchasing them. Also, since certain lease and rental payments made by a hospital can be passed through to medicare as a cost, hospitals have little incentive to negotiate favorable rates. Accordingly, I would like to hear from the GAO regarding the need to establish a specific test of reasonableness on the lease or rental payments for purposes of medicare reimbursement. My second concern has to do with the appropriateness of the current medicare policy of paying both buyer and seller for the costs of negotiating and completing an acquisition transaction. It seems to me it may be in the best interest of the taxpayers to exclude such costs under medicare.

Mr. Chairman, I view whatever action we would take now as interim steps until such time as capital payments are factored into the DRG prospective payment system. I would note, however, that subsequent testimony will raise concerns about excessive payments for capital costs under medicare because of the failure of medicare and its fiscal agents to apply properly the current rules for capital cost reimbursement.

Clearly, when we are at the point of holding current capital costs in the prospective payment system, we want to be assured by the administration that all previous excessive payments are excluded.

Mr. Chairman, I want to thank you and the subcommittees for the opportunity to appear this morning on this important issue.

Chairman JACOBS. Thank you for your testimony, Mr. Gradison.

Mr. Duncan?

Mr. DUNCAN. Thank you, Mr. Chairman.

I just want to thank our colleague.

I congratulate you on your aggressiveness and knowledge on this very important subject. I do not suppose there is a more knowledgeable person in the Congress than you are on health matters, and we look forward to your further help on this matter.

Thank you.

Mr. GRADISON. I thank the gentleman.

Chairman JACOBS. We will ask Mr. Gradison to participate in our panel.

The next witness is Nancy Gordon, Assistant Director for Human Resources and Community Development, Congressional Budget Office.

Dr. Gordon, we are both pleased and honored to have your participation and contribution to our record.

**STATEMENT OF NANCY M. GORDON, ASSISTANT DIRECTOR FOR HUMAN RESOURCES AND COMMUNITY DEVELOPMENT, CONGRESSIONAL BUDGET OFFICE, ACCOMPANIED BY ROSEMARY MARCUSS, ASSISTANT DIRECTOR FOR TAX ANALYSIS**

Ms. GORDON. Thank you very much, Mr. Chairman.

I am pleased to be here today. I am accompanied by Rosemary Marcuss, Assistant Director for Tax Analysis of the Congressional Budget Office.

I would appreciate it if you would include the full statement in the record, but I think that it would be appropriate to summarize.

Chairman JACOBS. It always is.

Ms. GORDON. I thought you would not object.

Although my statement will concentrate on hospital acquisitions, it is important to note just at the beginning that this issue is only part of a broader concern about overinvestment in the health care industry generally.

In recent years, there has been an increasing trend toward investor ownership of hospitals, particularly by chains. Most purchases involve investor-owned hospitals acquiring other investor-owned hospitals, but some public and private or nonprofit hospitals are also being bought.

Picking up at the top of page 3 of the statement, hospital acquisitions are occurring for several reasons. First, medicare and most

other insurers reimburse their shares of capital costs, either directly or indirectly. As a result of this third-party payment system, hospitals are not subject to the same constraints on their investment decisions as are other industries.

Second, new investment in hospitals is more likely to involve acquisition than new construction. Since need generally has to be demonstrated to state review boards before new hospitals can be constructed, investors have an incentive to take over existing facilities and thereby avoid lengthy approval processes.

In addition, the health care industry is responsive to much the same motivations and conditions that affect investment generally, including provisions of the Tax Code.

Since Mr. Markus has discussed the medicare system particularly, I will skip over to page 5 of the prepared statement.

Recent changes in tax law have encouraged both acquisitions and new construction throughout the economy. Under the Economic Recovery Tax Act, a major change affecting the hospital industry was the reduction in depreciation recovery periods for buildings and improvements from a minimum of 35 years to 15 years. For new buildings, the depreciation basis is construction cost; for existing buildings, it is sales price. Thus, whenever structures sell for more than they originally cost, their depreciation basis will increase upon transfer of the property. This, coupled with shorter recovery periods, raises aftertax returns and sales prices and encourages turnover.

Under current law, purchasers of health care facilities frequently also benefit from tax-exempt financing, which is available through small issue industrial revenue bonds [IRB's]. Since IRB's have a $10 million cap on the amount of the bond and on the total capital expenditure of the facility, they have provided low-cost financing primarily for acquiring individual hospitals, clinics, nursing homes, and other related facilities.

Hospital acquisitions have several effects. First, they directly increase medicare's payments for capital costs. The Congressional Budget Office estimates that over the 1985 to 1989 period, revaluation of new acquisitions will account for $750 million in medicare payments and another $80 million in medicaid payments.

Whether other insurers also pay more for hospital care because of acquisitions depends on the net effect of two factors—increased payments for capital and possibly lower payments for operating costs. Total hospital payments may be lower, for example, if multihospital systems are able to operate the hospital at a lower cost than the previous owner and if these efficiencies are translated into lower charges. Studies to date have not shown investor-owned hospital chains to be more efficient, however, although this situation might change in the future.

Hospital acquisitions may also affect the quality of care, but it is difficult to make general statements about whether quality would improve or decline. In some cases, the hospital being purchased is an older county-operated facility, and the quality of care might improve if the new owners modernize the hospital to a greater extent than the community would have. On the other hand, access to care by the poor might be reduced if the new owners do not provide the

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same level of care to medicaid beneficiaries or indigent patients as had previously been available.

The remainder of my statement analyzes ways that medicare's payments for capital costs associated with hospital acquisitions could be lowered, although one option would be to wait and consider this issue in conjunction with including capital costs in the prospective payment system. Because changes in tax policy would have effects far beyond the health care industry, they are not discussed.

First, medicare could simply continue to pay the same depreciation to the new owner as was paid to the previous owner, a change currently under consideration in the Senate. In addition, increases in the basis for interest and return-on-equity payments resulting from an acquisition could be disallowed. If both changes were in place beginning in fiscal year 1985, the 5-year savings to medicare and medicaid would total roughly $830 million.

Under this option, medicare's capital payments would not change as a result of new ownership. Despite this, a high proportion of acquisitions would probably still occur because the other incentives would remain in place. Some might argue that this approach is unfair, however, because it would not compensate the buyer for that part of the purchase price that represents the capital costs of replacing the assets acquired.

Another option that has been suggested would extend medicare's recapture provision by collecting part of the capital gain earned on the sale, with medicare's proportion based on the share of the hospital's costs that medicare represented. Depreciation, interest, and return on equity would be paid to the new owner as under current law.

Under this approach, all of medicare's gains from the sale of nonprofit or Government-operated hospitals and part of the gains from the sale of investor-owned hospitals would represent completely new Federal revenue. These savings would also be achieved immediately. On the other hand, it is possible that more acquisitions would be discouraged than under the previous option. If so, medicare's recapture of past depreciation payments would fall.

In conclusion, Mr. Chairman, a number of factors, including several Federal policies, encourage the acquisition of hospitals, which in turn increases medicare's payments. Consequently, in addition to deciding how to include capital costs in medicare's prospective payments rates, the Congress may wish to make intermediate changes. In doing so, however, it is important to remember that any changes made now might influence the design of the final capital reimbursement system.

That completes my prepared statement. I would be pleased to answer any questions.

[The prepared statement follows:]

STATEMENT OF NANCY M. GORDON, ASSISTANT DIRECTOR FOR HUMAN RESOURCES AND COMMUNITY DEVELOPMENT, CONGRESSIONAL BUDGET OFFICE

Mr. Chairman, I am pleased to be here to discuss the effects of federal policies on hospital acquisitions, which are of interest particularly because they increase Medicare's costs. Although my statement will concentrate on hospital acquisitions, it is important to note that this issue is only part of a broader concern about over-investment in the health-care industry generally. My statement today will cover:

- Recent trends in hospital investment;
- The reasons for increased purchases of hospitals;
- The effects of these acquisitions on Medicare and the overall health-care system; and
- Some possible alternatives to current policy.

## RECENT TRENDS IN HOSPITAL INVESTMENT

In recent years, there has been an increasing trend toward investor ownership of hospitals, particularly by chains. Most purchases involve investor-owned hospitals acquiring other investor-owned hospitals, but some public and private nonprofit hospitals are also being bought.

Between 1972 and 1982, the number of hospitals remained virtually unchanged, while the total number of beds increased by 15 percent, which was slightly higher than the increase in population during the same period. Although growth in total hospital capacity has not been dramatic, significant changes are occurring in the makeup of the industry. Between 1972 and 1982, the number of beds in public hospitals increased by only 2 percent; in contrast, the number increased by 15 percent in private, nonprofit hospitals and by 60 percent in investor-owned hospitals.

At present, investor-owned hospitals account for roughly 10 percent of all hospital beds. Within the investor-owned segment, the number of hospital chain operations has been growing over the past five years, while the number of independent hospitals has declined. Between 1978 and 1983, the number of hospitals operated by chains of three or more facilities increased by 72 percent; the number of beds in these hospitals increased by 62 percent. Conversely, both the number of independent investor-owned hospitals and the number of beds in them decreased by 34 percent.

In addition to acquisitions of existing hospitals, the number of investor-owned facilities under construction has increased. Between 1981 and 1983, the capacity of these new hospitals expanded by an average of about 6,900 beds a year, compared with an annual average increase of 4,700 beds during the preceding three years--an increase of 47 percent.

REASONS FOR INCREASED ACQUISITIONS

Investment in health care--and, in particular, acquisitions of existing facilities--is occurring for several reasons. Some of these are unique to the health-care industry. For example:

- Medicare and most other insurers reimburse their shares of capital costs, either directly or indirectly. As a result of this third-party payment system, hospitals are not subject to the same constraints on their investment decisions as other industries.

- New investment in hospitals is more likely to involve acquisition than new construction. Since "need" generally has to be demonstrated to state review boards before new hospitals can be constructed, investors have an incentive to take over existing facilities and thereby avoid lengthy approval processes. Hospital purchasers are most likely to be investor-owned chains, because they have better access to the equity and debt capital needed to purchase and modernize existing facilities.

Although the health-care industry is in some ways unique, it is also responsive to much the same motivations and conditions that affect investment generally. The tax cuts enacted in the Economy Recovery Tax Act of 1981 (ERTA), which accelerated depreciation and increased invest-

ment tax credits, have generally tended to encourage periodic sales of facilities.

Although both Medicare policies and tax provisions encourage hospital acquisitions, the relative significance of these incentives and their aggregate effects are difficult to quantify. It seems likely, however, that overall profit opportunities and general tax advantages are more important than the increase in Medicare's reimbursements for capital costs that occurs upon a change in ownership.

Medicare's Reimbursement Policies

Currently, capital costs--that is, payments for depreciation, interest costs, and also for return-on-equity to investor-owned hospitals--are excluded from Medicare's prospective payment system and continue to be reimbursed on a reasonable cost basis. Medicare's depreciation payments are based on historical costs and made on a straight-line basis over the useful life of the asset--generally 40 years for a new hospital building.

When a hospital is purchased, several factors raise Medicare's costs. First, the buyer is permitted by Medicare's reimbursement rules to revalue assets and use a new depreciation schedule based on the sale price. 1/

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1. Medicare limits the revalued amount to the lower of either the purchase price or the current cost of reproducing the facility, less depreciation on the reproduction cost to reflect the actual age of the assets that were purchased.

Return-on-equity payments also increase because they are based on the revalued amount. Finally, Medicare reimburses its share of interest costs on borrowing used to finance the purchase. On the other hand, Medicare "recaptures" past depreciation payments by requiring that the seller pay Medicare any profit earned on the sale, up to an amount equal to the total of all depreciation payments Medicare has made to the seller over past years. 2/

Tax Provisions

Recent changes in tax law have encouraged both acquisitions and new construction throughout the economy. Under ERTA, the depreciation recovery periods for both structures and equipment were substantially shortened, and the investment tax credit for equipment was increased. The major change affecting the hospital industry was the reduction in depreciation recovery periods for buildings and improvements from a minimum of 35 years to 15 years. For new buildings, the depreciation basis is construction cost; for existing buildings, it is sales price. Thus, whenever structures sell for more than they originally cost, their depreciation basis will increase upon transfer of the property. This, coupled with shorter recovery periods,

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2. Capital gains taxes are paid by the sellers of an investor-owned hospital on any profit that exceeds Medicare's recapture of past depreciation payments, but the sellers of a nonprofit hospital are not subject to this tax.

raises after-tax returns and sales prices and encourages turnover. The new rules on movable equipment are less likely to stimulate acquisitions. 3/

Under current law, purchasers of health-care facilities frequently benefit not only from generous tax write-offs, but also from tax-exempt financing. The large investor-owned chains have access to many forms of debt and equity capital, including tax-exempt bonds. They receive tax-exempt financing through small issue industrial revenue bonds (IRBs), which have a $10 million cap on the amount of the bond and on the total capital expenditure on the facility. Although not suited for major hospital complexes, small issue IRBs have provided low-cost financing for acquisition of individual hospitals, clinics, nursing homes, physician-owned medical office buildings, and other related facilities.

## EFFECTS OF INCREASED ACQUISITIONS ON MEDICARE AND THE OVERALL HEALTH-CARE SYSTEM

Hospital acquisitions directly increase Medicare's payments for capital costs. The Congressional Budget Office (CBO) estimates that over the 1985 to 1989 period, revaluation of new acquisitions will account for $750 million of Medicare payments, and another $80 million in Medicaid payments, because many state Medicaid programs follow Medicare's reimbursement rules.

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3. Most hospital equipment can be depreciated in three to five years, which may be more favorable than previous law in some cases and less favorable in others. For used property, the investment tax credit is limited to the first $125,000 of cost.

Whether other insurers also pay more for hospital care because of acquisitions depends on the net effect of two factors--increased payments for capital and possibly lower payments for operating costs. Insurers other than Medicare pay more as a result of acquisitions either directly, through cost reimbursement of capital similar to Medicare's, or indirectly through higher charges for services. Total hospital payments may be lower, however, if multihospital systems are able to take advantage of economies of scale in management or make other improvements to operate the hospital at lower cost than the previous owner, and if these efficiencies are translated into lower charges. (This offset would not affect Medicare, at least in the short-run, because prospective payment rates are not directly related to a hospital's costs.) Studies to date have not shown investor-owned hospital chains to be more efficient, however. This situation may reflect little more than the lack of incentives for efficiency under cost reimbursement, though, so some speculate that it might change in the future. 4/

Hospital acquisitions may also affect quality of care, but it is difficult to make general statements about whether quality would improve or decline because of the diversity of specific situations. For example, in some cases,

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4. One study of California hospitals found that investor-owned chains had operating expenses per admission 2 to 5 percent higher than other non-public hospitals. Robert V. Patterson and Hallie M. Katz, "Investor-Owned and Not-for-Profit Hospitals", New England Journal of Medicine, August 11, 1983, pp. 347-353.

the hospital being purchased is an older, county-operated facility and the quality of care might improve if the new owners modernize the hospital to a greater extent than the community would have. Indeed, anecdotal evidence suggests that inability to modernize may sometimes be the reason for the sale. 5/ On the other hand, access to care by the poor might be reduced, if the new owners do not provide the same level of care to Medicaid beneficiaries or indigent patients as had previously been provided by the community. Effects of ownership change on access may not be as important when the hospital being acquired is an independent investor-owned facility, however.

## OPTIONS

Medicare's payments for capital costs associated with hospital acquisitions could be reduced by changing reimbursement policy. In addition, changes in tax policy could affect hospital acquisitions; tax policy changes are an indirect means of regulating investment, however, and would have effects that reach far beyond the health-care industry. For these reasons, the options presented here deal only with Medicare policies.

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5. In the case of government hospitals, inability to finance improvements may be the result of difficulties in gaining voter approval for bond issues. Also, in these and other cases, an independent facility faces higher borrowing costs than chains, which are less risky because their earnings depend on the performance of several hospitals.

Because the Congress plans to include payments for capital costs in the prospective payment system by 1987, intermediate steps to change--and perhaps further complicate--Medicare's reimbursement rules related to hospital acquisitions might not be desirable. This would especially be true if the intermediate changes made the expansion of prospective payment more difficult. On the other hand, depending on the design and the length of the transition to complete prospective payment of capital costs, current and future acquisitions could continue to raise Medicare's outlays for many years. Given the pressure on the federal budget as a whole, the Congress might want to avoid this outcome by modifying Medicare's reimbursement rules now.

Disallow Revaluation of Assets for Medicare Reimbursement

Instead of reimbursing the higher capital costs related to hospital acquisitions, Medicare could simply continue the same depreciation payments made to the previous owner--a change currently under consideration. In addition, increases in the basis for interest and return-on-equity payments resulting from an acquisition would be disallowed. If this option were in place beginning in fiscal year 1985, five-year savings to Medicare and Medicaid would total roughly $830 million.

Under this option, Medicare's capital payments would not change as a result of new ownership. Despite the fact that payments to a new owner

would be less than under current law, a high proportion of acquisitions would probably still occur. In fact, the tax system would offset some of the lost Medicare payments--most acquisitions are made by taxable entities--because the new owner's tax liability would also decline. On the other hand, some might argue that this approach is unfair because it would not compensate the buyer for that part of the purchase price that represents the capital costs of replacing the assets acquired. Moreover, it might significantly reduce the profits of some hospital owners.

Allow Medicare to Share in Capital Gains

Another option that has been suggested would extend Medicare's recapture provision by collecting part of the capital gain earned on the sale, with Medicare's proportion based on the share of the hospital's costs that Medicare represented. For example, if a hospital received $2 million on the sale (over and above repayments to Medicare for past depreciation) and Medicare's share of costs had averaged 40 percent, Medicare would receive $800,000. As under current law, the new owner could begin a depreciation schedule based on the new purchase price, and Medicare would pay all interest and return-on-equity payments associated with the sale.

Under this approach, Medicare's gains from the sale of nonprofit or government-operated hospitals would represent completely new federal income, because these sales are not subject to capital gains taxes. In

addition, a portion of the payments from the sales of investor-owned hospitals would be new revenue. (The remainder would be offset by a reduction in capital gains taxes paid by the seller.) 6/ Medicare savings would also be achieved immediately, rather than accrued slowly over time. On the other hand, it is possible that more acquisitions would be discouraged than under the previous option. If so, Medicare's recapture of past depreciation payments would fall. Moreover, in cases involving the sale of a government-operated facility to an investor-owned hospital chain, some might find it more desirable to pay the purchaser less over time (under the first option that prohibits revaluation) than to collect money from the seller at the time of purchase.

## CONCLUSION

A number of factors, including several federal policies, encourage the acquisition of hospitals, which in turn increases Medicare's payments. Consequently, in addition to deciding how to include capital in Medicare's prospective payment rates, the Congress may wish to make intermediate changes in Medicare's reimbursement of capital. In doing so, however, it is important to remember that any changes made now might influence the design of the final reimbursement system.

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6. Total federal revenue would be the same whether Medicare shared in the before-tax or after-tax capital gains, but the distribution between receipts to the Hospital Insurance (HI) trust fund and receipts to the general treasury would vary. The HI trust fund would receive more if the before-tax capital gains were shared with Medicare, and the seller was taxed only on the remainder.

Chairman JACOBS. Thank you, Dr. Gordon.

Mr. Duncan?

Mr. DUNCAN. I have no questions, Mr. Chairman.

Chairman JACOBS. Mr. Gradison?

Mr. GRADISON. Thank you, Mr. Chairman.

Some questions have been raised about the accuracy of the cost projections by CBO, and I would appreciate it if you would tell us a little bit more about how these were developed and whether you have reexamined them in light of questions that have been raised about the $750 million medicare figure and the $80 million medicaid figure for the next 5 fiscal years.

Ms. GORDON. Yes, sir. We have spoken to some of the people who expressed concern about those estimates. As we all know, though the data on which these estimates are based are the best data available, they are very poor. So I think everyone believes that there is a wide range of uncertainty around the estimate.

The particular concern that was expressed to us had to do with the impact of changing medicare's reimbursement policies on the number of acquisitions that would occur. If you believe that changing medicare's policies would sharply reduce the number of acquisitions, then medicare would recapture less of the past depreciation payments and that would in fact offset the savings that we show.

The CBO believes, however, that there are many different factors that go into decisions to acquire hospitals, and that changing medicare's reimbursement policies would have a relatively modest effect. Therefore, there would be roughly the same number of acquisitions.

Mr. GRADISON. Thank you.

Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Dorgan?

Mr. DORGAN. No questions.

Chairman JACOBS. Doctor, thank you very much for your testimony.

Ms. GORDON. Thank you.

Chairman JACOBS. The next witness is Michael Zimmerman, Associate Director of Health Financing Programs, Human Resources Division, U.S. General Accounting Office.

## STATEMENT OF MICHAEL ZIMMERMAN, ASSOCIATE DIRECTOR OF HEALTH FINANCING PROGRAMS, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY THOMAS DOWDAL AND KENNETH BRAKE

Mr. ZIMMERMAN. Mr. Chairman, I would like to begin by introducing the people who are with me today. To my left is Tom Dowdal. Mr. Dowdal is responsible for our work in the medicare area. And to my right is Ken Brake. Mr. Brake is responsible, or was responsible, for the work involving the merger.

We are pleased to be here today to discuss how hospital mergers can increase payments for capital costs. Our review of one large merger showed substantial increases in capital costs resulting from a change in ownership. The medicare and medicaid programs will reimburse the new owner for some of the increase in costs, and future acquisitions will also increase medicare and medicaid pay-

ments for capital costs unless the present cost reimbursement system is changed.

The Social Security Amendments of 1983 provide for incorporating capital costs into the prospective payment system by October 1, 1986, if a plan acceptable to the Congress is developed.

The first part of my statement will focus on the information presented in our December 22 report to Representative Gradison. Next I will briefly discuss the incentives for acquisitions provided by the Federal Income Tax Code. Finally, I will describe some of the ways States under medicaid reimburse capital costs for nursing homes after acquisitions.

As requested by Representative Gradison, we examined the Hospital Corporation of America acquisition of Hospital Affiliates International to show what can happen to costs when hospitals change ownership.

On August 26, 1981, HCA purchased HAI's assets, which consisted of 54 hospitals, 18 nursing homes, at least 10 medical office buildings, and 42 other corporate entities such as hospital management companies, a transaction amounting to about $1 billion. Our analysis of HCA's corporate records focused on changes in interest expense, depreciation, and home office expenses, because these costs are most likely to change significantly as the result of an acquistion.

Our analysis showed that during the first year after the acquisition, the 54 acquired hospitals' costs increased by about $55 million. These increased costs will have to be recouped through increased revenues from hospital payors or absorbed by HCA, which would result in decreased corporate earnings. We estimate that overall annual interest costs increased by about $62.5 million, nearly tripling, because of borrowing to finance the acquisition.

In addition, depreciation on the hospitals and medical office buildings increased by about $8.4 million per year, almost 90 percent, as a result of HCA's revaluing these acquired assets. Based on information from HCA officials and unaudited home office cost reports, the estimated home office cost savings for the first year were about $15.7 million. Officials said that the savings resulted from home office staffs being reduced and home office costs being spread over more hospitals.

To measure the effect on medicare and medicaid costs, we allocated HCA's claimed costs for depreciation, interest, and home office expenses to these programs for two hospitals suggested by HCA. We estimated that for the year following the acquisition at the two hospitals the increase in capital costs per patient day allocated to medicare in HCA's cost reports was about $26 and $21 respectively, and the increase in capital costs per patient day allocated to medicaid at the two hospitals was about $31 and $27 respectively.

In our report we questioned the procedures HCA used for medicare cost reporting purposes to allocate interest to the acquired hospitals and to value the acquired assets and to compute depreciation on them. The HCA methods that we questioned tend to increase medicare payments to the hospitals. Medicare's paying agents have not yet determined the amount of increased costs the

program will allow, and they may disallow the items we questioned when a final determination of the hospitals' allowable cost is made.

HCA generally disagreed with our findings, and believes it has correctly claimed reimbursement from medicare in accordance with the program's policies. We believe, however, that HCA has misinterpreted medicare reimbursement policy, and that the questions we raised concerning the costs it claimed are appropriate. We recommended that HHS consider our findings when finalizing payments to HCA related to the HAI acquisition and clarify the medicare policies discussed in the report to prevent misinterpretations by providers in future acquisitions.

Another reason to clarify the medicare policies on acquisitions is that if an acceptable method for including capital costs in prospective payments is developed, it will be important to know what allowable costs were in the past and will be in the future because prospective payment rates are normally based on costs.

We believe that the current medicare reimbursement policies for capital costs are relatively neutral toward influencing a decision to buy or sell a hospital. That is, because medicare payments are based on the new owner's costs—with some limitations—they do not provide a large incentive one way or another to anyone considering selling or buying a hospital. However, medicare's policies do remove much of the risk from purchasing a hospital because the buying entity is guaranteed payment of its capital costs to the extent that medicare beneficiaries use the hospital.

Another set of policies, namely, Federal tax policies designed to stimulate investment in new facilities and equipment, can provide incentives toward buying and selling existing hospitals. For example, Federal income tax law permits owners of real property such as hospital buildings to use accelerated depreciation over a 15-year period.

Thus a hospital building, which according to the American Hospital Association normally has an estimated useful life of 40 years, can be fully written off in 15 years. From an income tax standpoint, it may pay to change ownership every 6 or 7 years, because by that time more than half of the facility's depreciation can be taken.

Also, from the seller's viewpoint, some of the gain made on a sale may be taxed as long-term capital gain, of which only 40 percent is taxable as income. From the buyer's viewpoint, interest on any loans obtained to finance the acquisition as well as accelerated depreciation on a hospital's newly established value are deductible from income.

Also, the buyer may be able to qualify for an investment tax credit on at least some of the equipment acquired.

In response to the subcommittees' request, we identified alternatives to current medicare policies for recognizing capital costs after an acquisition. Before discussing these alternatives, however, I would like to discuss a rationale that could be used for controlling capital costs after a sale.

Under a cost-based system for capital costs, when a hospital enters a program, the hospital and the Government in effect enter into an agreement under which the hospital agrees to serve Government beneficiaries at the payment rate resulting from the Gov-

ernment's reimbursement rules and the Government agrees to pay the hospital its capital costs. Over the facility's life, the Government will fully pay for that part used by its beneficiaries. If the hospital is sold and because of factors not related to the program the new owner's capital costs are higher than those of the old owner, the Government should not be obligated to pay these increased costs.

The rationale for this is that the Government is only going to pay for the facility once based on its original costs. On the other hand, the rationale from the hospital seller's and buyer's perspective for allowing payments for capital costs to increase is that the hospital's circumstances have changed, and the Government should recognize this change.

The seller would argue that not recognizing increased capital costs would diminish the property's value because a buyer would not pay as much for it knowing that the government would not allow passing through all increased costs.

Turning now to the alternatives, one alternative would limit the buyer's allowable depreciation to the level allowed to the seller. Wisconsin has this kind of a policy for medicaid nursing homes. This would keep depreciation constant after the sale. However, medicare savings would be relatively small, as would the impact on the buyer, because increases in interest costs are often much higher than increases in depreciation.

Another alternative would limit capital costs to maximum amounts per day based on the facility's age. The maximum amounts would be set based on construction costs per bed when the facility was built or began participating in the program. Ohio uses this limitation under medicaid for all nursing homes regardless of whether a sale is involved, but medicare could use the policy for sales only. The buyer could receive actual interest and depreciation expenses unless they exceeded the limit. This policy would establish a ceiling on the increases in capital costs.

Another alternative would limit capital costs after sales to the capital costs incurred by a selected percentage of hospitals. For example, Kansas limits payment for nursing homes under medicaid to the costs incurred by 85 percent of the nursing homes participating in medicaid. Kansas applies this limit to all facilities, but medicare could apply it only to the acquired facilities. The buyer could receive actual capital costs unless they exceed the limit. The percentile at which the limit is established can be selected to achieve the level of savings desired.

A final alternative limits capital payments to amortization based on the seller's mortgage payment. New York uses this policy based on the original provider's mortgage payments for proprietary nursing homes participating in medicaid. This policy in effect pays the original owner's cash flow needs for capital related costs. If a buyer's capital cash flow needs are higher than the seller's, New York does not recognize them. This policy does not pay depreciation in the traditional sense, but rather pays the principal based on the original owner's mortgage.

There are many possible variations of the policies outlined above. Each policy and each variation would produce different savings for

medicare and would have different impacts on buyers and sellers. Also, each could provide different incentives.

For example, controlling only depreciation increases should have little impact on buyers and sellers and should produce limited medicare savings. On the other hand, if no increase in interest or depreciation were allowed, a buyer would probably think twice before paying much more for a hospital than its depreciated book value, and medicare savings should be much larger.

None of the policies discussed above specifically addresses controlling changes in medicare's return of equity payments, but the same type of limitations could be placed on them. Also, under medicare's hospital prospective payment system, hospitals can now realize a profit by holding their operating costs below the prospective payment level. Some have questioned whether given this it is also necessary to pay a return on equity as well. Under their medicaid program, a number of States do not directly include a return-on-equity payment in computing their prospective payment rates for nursing homes.

This concludes my statement. We will be glad to answer any questions you may have.

[The prepared statement follows:]

STATEMENT OF MICHAEL ZIMMERMAN, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and members of the Subcommittees, we are pleased to be here today to discuss how hospital mergers can increase Medicare and Medicaid payments for capital costs. Our review of one large merger showed substantial increases in capital costs resulting from a change in ownership. The Medicare and Medicaid programs will reimburse the new owner for some of the increase in costs. Future acquisitions will also increase Medicare and Medicaid payments for capital costs unless the present cost reimbursement system is changed. The Social Security Amendments of 1983 (P.L. 98-21) provide for incorporating capital costs into the prospective payment system by October 1, 1986, if a plan acceptable to Congress is developed.

The first part of my statement will focus on the information presented in our report to Representative Gradison entitled "Hospital Merger Increased Medicare and Medicaid Payments for Capital Costs" (GAO/HRD-84-10, December 22, 1983). Next, as you requested, I will briefly discuss the incentives for acquisitions provided by the federal income tax code. Finally, I will describe some of the ways states under Medicaid reimburse capital costs for nursing homes after acquisitions.

THE GAO REPORT

As requested by Representative Gradison, we examined the Hospital Corporation of America (HCA) acquisition of Hospital Affiliates International (HAI) from INA Corporation to show what can happen to costs when hospitals change ownership. On August 26, 1981, HCA purchased HAI's assets, which consisted of 54 hospitals, 18 nursing homes, at least 10 medical office buildings, and 42 other corporate entities such as hospital management companies. HCA paid $425 million in cash (which HCA borrowed) and 5.39 million shares of stock valued at $190 million. In addition, HCA assumed HAI's debt of about $270 million.

*Costs increased substantially*

Our analysis of HCA's corporate records focused on changes in interest expense, depreciation, and corporate-level management expense (home office expense) because these costs are most likely to change significantly as the result of an acquisition. Our analysis showed that, during the first year the acquisition, the 54 acquired hospitals' costs increased by about $55 million. These increased costs will have to be recouped through increased revenues from hospital payors or absorbed by HCA, which would result in decreased corporate earnings.

We estimated that overall annual interest costs increased by about $62.5 million, nearly tripling, because of borrowing to finance the acquisition. In addition, depreciation on the hospitals and medical office buildings increased by about $8.4 million per year, almost 90 percent, as a result of HCA's revaluing these acquired assets. Based on information from HCA officials and unaudited home office cost reports, the estimated home office cost savings for the first year were about $15.7 million. Officials said that the savings resulted from home office staffs being reduced and home office costs being spread over more hospitals.

*Effect of HCA's increased capital costs on medicare and medicaid costs*

To measure the effect on Medicare and Medicaid costs, we allocated HCA's claimed costs for depreciation, interest, and home office expenses to these programs for two hospitals suggested by HCA. We estimated that for the third year following the acquisition:

The overall increase in costs due to changes in these three items was about $1 million at one hospital and $300,000 at the other.

The portion of these increased capital costs allocated by HCA to Medicare and Medicaid was $465,000 at one hospital and and $117,000 at the other.

At the two hospitals, the increase in capital costs per patient day allocated to Medicare in HCA's cost reports was about $26 and $21, respectively.

At the two hospitals, the increase in capital costs per patient day allocated to Medicaid in HCA's cost reports was about $31 and $27, respectively.

*HCA misinterpreted medicare reimbursement policy*

Medicare policies permit assets to be revalued and additional interest and depreciation expenses to be reimbursed following changes in provider ownership if certain conditions are met. However, Medicare reimbursement policies include some controls that limit the increases. For example, Medicare will not pay for purchased goodwill—that is, the amount paid to the seller that exceeds the market value of the acquired assets—and Medicare has controls over the methods used to assign a fair market value to acquired assets.

We questioned the procedures HCA used for medicare cost reporting purposes (which are also generally used by medicaid) to allocate interest to the acquired hospitals and to value the acquired assets and compute depreciaton on them. HCA based its position on its interpretation of medicare policies and on Generally Accepted Accounting Principles (GAAP), which are designed to provide rules for reporting the financial position, results of operations, and changes in the financial position of an entity for present and potential investors and creditors. Although GAAP normally represents the appropriate principles for financial reporting purposes, it is not always appropriate for a cost reimbursement system such as medicare uses. Under medicare, GAAP can be used only when medicare's principles of reimbursement do not cover a situation.

The HCA methods that we questioned would tend to increase medicare payments to the hospitals. Medicare's paying agents have not yet determined the amount of increased costs the program will allow, and they may disallow the items we questioned when a final determination of the hospitals' allowable costs is made. Specifically, HCA used the following methods that we questioned:

HCA allocated debt and related interest to medicare using a method different from the one prescribed by the program. This resulted in higher capital costs being allocated to medicare.

HCA discounted the debt assumed from HAI that bore interest rates below the market rate at the time of acquisition. The effect of discounting was to increase the interest claimed from medicare.

HCA assigned inaccurate values to the real assets because of inconsistent practices in the appraisal and depreciation processes. Specifically, (1) useful lives used in appraising the acquired assets were different from the medicare-approved lives used in depreciating them, (2) acquired assets were assumed to have no salvage value when depreciation was calculated, and (3) values were assigned to leased assets that resulted in higher interest and depreciation expenses being claimed. In addition, the appraisals' independence and accuracy are questionable because the appraised values were changed at HCA's request. This change woud have the effect of increasing the assets' value by $28.2 million above the value that would have been computed using medicare-approved useful life estimates and thus increase the allowable debt and depreciable base by the same amount.

HCA generally disagreed with our findings and believes it has correctly claimed reimbursement from medicare in accordance with the program's policies. We be-

lieve, however, that HCA has misinterpreted medicare reimbursement policy and that the questions we raised concerning the costs it claimed are appropriate.

We recommended that HHS (1) consider our findings when finalizing payments to HCA related to the HAI acquisition and (2) clarify the medicare policies discussed in the report to prevent misinterpretations by providers in future acquisitions.

Another reason to clarify the medicare policies on accounting for acquisitions is that, if an acceptable method for including capital costs in prospective payments is developed, it will be important to know what allowable costs were in the past and will be in the future because prospective payment rates are normally based on costs.

### THE FEDERAL INCOME TAX SYSTEM CAN PROVIDE INCENTIVES FOR CHANGES IN OWNERSHIP

We believe that current medicare reimbursement policies for capital costs are relatively neutral toward influencing a decision to buy or sell a hospital. That is, because medicare payments are based on the new owner's costs (with some limitations), they do not provide a large incentive one way or the other to anyone considering selling or buying a hospital. However, medicare's policies do remove much of the risk from purchasing a hospital because the buying entity is guaranteed payment of its capital costs to the extent that medicare beneficiaries use the hospital. Also, the entity can retain under the prospective payment system any savings it can generate through operating efficiencies. But medicare policy is only one of the federal policies involved. Another set of policies, namely federal tax policies designed to stimulate investment in new facilities and equipment, can provide incentives toward buying and selling existing hospitals. A few examples follow.

Federal income tax law permits owners of real property such as hospital buildings to use accelerated depreciation over a 15-year period. Thus, a hospital building, which according to the American Hospital Association normally has an estimated useful life of 40 years, can be fully written off in 15 years. From an income tax standpoint, it may pay to change ownership every 6 or 7 years because, by that time, more than half of the facility's depreciation can be taken. Also, from the seller's viewpoint, some of the gain made on the sale may be taxed as a long term capital gain, of which only 40 percent is taxable as income. From the buyer's viewpoint, interest on any loans obtained to finance the acquisition as well as accelerated depreciation on the hospital's newly established value are deductible from income. Also, the buyer may be able to qualify for an investment tax credit on at least some of the equipment acquired.

### ALTERNATIVE PAYMENT METHODS FOR CAPITAL COSTS AFTER ACQUISITIONS

Capital costs consist primarily of interest and depreciation costs. As shown by our report on one merger, both of these costs can increase substantially after an acquisition. Another capital cost which Medicare pays that can be significantly affected by an acquisition is return on equity. Depending mainly on the difference in investment between the old and new owners, return on equity could either increase or decrease.

In response to the Subcommittees' request, we identified alternatives to current Medicare policies for recognizing capital costs after an acquisition. We reviewed the various mechanisms states use under Medicaid for this purpose as well as other possible methods. We identified a range of options that vary from allowing no change in capital costs after an acquisition to imposing less stringent controls on only the depreciation side of capital costs.

First, I would like to discuss a rationale that could be used for controlling capital costs after a sale. Under a cost-based reimbursement system for capital costs, when a hospital enters the program, the hospital and the government in effect enter an agreement under which the hospital agrees to serve government beneficiaries at the payment rate resulting from the government's reimbursement rules and the government agrees to pay the hospital its actual capital costs. Over the facility's life, the government will fully pay for that part used by its beneficiaries. If the hospital is sold and because of factors not related to the program (increased land values, inflation in the cost of building hospitals, etc.) the new owner's capital costs are higher than those of the old owner, the government should not be obligated to pay these increased costs. The rationale for this is that the government is only going to pay for the facility once based on its original costs.

On the other hand, the rationale from the hospital seller's and buyer's prospective for allowing payments for capital costs to increase is that the hospital's circumstances have changed and the government should recognize this change. The seller would argue that not recognizing increased capital costs would diminish the proper-

ty's value because a buyer would not pay as much for it knowing that the government will not allow passing through all increased costs.

A range of alternatives follows:

Limit the buyer's allowable depreciation to the level allowed to the seller. Wisconsin has this kind of a policy for Medicaid nursing home payments. This would keep depreciation constant after the sale. However, Medicare savings would be relatively small, as would the impact on the buyer, because increases in interest costs are often much higher than increases in depreciation.

Limit capital costs to maximum amounts per day based on the facility's age. The maximum amounts would be set based on construction costs per bed when the facility was built or began participating in the program. Ohio uses this limitation under Medicaid for all nursing homes regardless of whether a sale is involved, but Medicare could use the policy for sales only. For example, in Ohio, for a facility constructed and/or licensed between December 31, 1957, and January 1, 1968, the payment shall not exceed (a) $3.50 per inpatient day if the cost of construction was $3,500 or more per bed, or (b) $2.50 per inpatient day if the cost of construction was less than $3,500 per bed.

The buyer could receive actual interest and depreciation expenses unless they exceed the limit. This policy would establish a ceiling on the increases in capital costs. It would require establishing cost limits based on construction costs at the time a facility was built or entered the program. This could be difficult for older facilities because the records identifying costs may not be readily available.

Limit capital costs after sales to the capital costs incurred by a selected percentage of hospitals. For example, Kansas limits payments for nursing homes under Medicaid to the costs incurred by 85 percent of the nursing homes participating in Medicaid. Kansas applies this limit to all facilities, but Medicare could apply it only to acquired facilities. The buyer could receive actual capital costs unless they exceeded the limit. The percentile at which the limit is established can be selected to achieve the level of savings desired or accomplish another policy objective.

Limit capital payments to amortization based on the seller's mortgage payment. New York uses this policy, based on the original provider's mortgage payments, for proprietary nursing homes participating in Medicaid. This policy in effect pays the original owner's cash flow needs for capital-related costs. If a buyer's capital cash flow needs are higher than the seller's, New York does not recognize them. This policy does not pay depreciation in the traditional sense, but rather pays the principal based on the original owner's mortgage.

There are many possible variations of the policies outlined above. Each policy and each variation would produce different savings for Medicare and would have different impacts on buyers and sellers. Also, each could provide different incentives to buyers and sellers. For example, controlling only depreciation increases should have little impact on buyers and sellers and should produce limited Medicare savings. On the other hand, if no increase in interest or depreciation were allowed, a buyer would probably think twice before paying much more for a hospital than its depreciated book value and Medicare savings should be much larger.

None of the policies discussed above specifically address controlling changes in Medicare's return of equity payments, but the same types of limitations could be placed on them. Also under Medicare's hospital prospective payment system, hospitals can now realize a profit by holding their operating costs below the prospective payment level. Some have questioned whether, given this, it is also necessary to pay a return on equity as well. Under their Medicaid programs, a number of States do not directly include a return on equity payment in computing their prospective payment rates for nursing homes.

This concludes my statement. We will be glad to answer any questions you may have.

Chairman JACOBS. Mr. Rangel?

Chairman RANGEL. No questions, Mr. Chairman.

Chairman JACOBS. Mr. Duncan?

Mr. Gradison?

Mr. GRADISON. Thank you very much, Mr. Chairman.

Mr. Zimmerman, it is my understanding that the auditing activities of the Health Care Financing Administration with respect to acquisitions of this kind currently are carried out by the intermediaries wherever they may be located or, for example, in case of

the HCA acquisition by the intermediary that would normally serve the Tennessee area.

From your observations, what would you think of the idea of having a special auditing unit within HCFA to do audits on these large mergers?

Mr. ZIMMERMAN. I think it would be a good idea to establish some kind of special unit in view of the complexity and size of these mergers. As to whether that ought to be a permanently established one, I would probably say not. It would seem to me some kind of task force approach that would enable HCFA to bring together the best people in its organization as well as obtaining from the various intermediaries the best people they have—these are obviously very complicated transactions, and I do not think we should rely on anything short of having the best talent in the agency put to work on it.

Mr. GRADISON. One final question, Mr. Chairman.

Mr. Zimmerman, there has been discussion of some kind of a limitation on the amount of the depreciation base that would be recognized and limiting it to the seller's basis. The Senate Finance Committee has a provision in its tax bill along these lines. It would seem to me that there might be a potential loophole in that kind of a proposal, that is, that it might be possible to circumvent the limitations by the use of some kind of sale and leaseback arrangements.

I wonder whether this is a legitimate concern and whether if we are going to legislate in this area at all we should examine the possibility of extending the provisions to sale and leaseback as well as total actual clearcut sales.

Mr. ZIMMERMAN. I would have to agree that would probably be a good idea. Mr. Dowdal is my expert on loopholes, and I might ask him to add anything he wants to on that point.

Mr. DOWDAL. Well, there is definitely a potential to use that kind of mechanism to get around the limits. How much sale and leaseback would be used we would not be able to say, but there is a potential for that, so adding a control into any bill that was enacted would probably be a good idea.

Mr. GRADISON. Thank you for your testimony, as well as for your help on the study.

Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Gradison.

Mr. Moore?

Mr. MOORE. No questions, Mr. Chairman.

Chairman JACOBS. Mr. Zimmerman, have you an opinion as to how much would have been saved for the Government if the medicare rules had been applied in this acquisition?

Mr. ZIMMERMAN. Are you thinking in terms of some of the proposals that are being put forth limiting it?

Chairman JACOBS. No, I understand that the rules as they exist were somewhat ambiguous and the merger was so immense that in effect they may or may not have been applied.

Mr. ZIMMERMAN. I do not have a figure offhand. I will ask Mr. Dowdal. He may be able to shed some light on that.

Mr. DOWDAL. There were so many different issues that we raised that we never tried to bring them all together and compute a

number, a bottom line number, because each one of the individual issues impacted on all of the others. However, if I had to make a rough guess of what the amount would be, it would probably be in the neighborhood of half of what ended up in the medicare costs reports. This amount would not have been in the cost reports if all of the rules would have been applied in the manner that we suggested that they be applied.

Chairman JACOBS. So the secret is to be as complicated as you possibly can?

Mr. DOWDAL. Well, it never hurts.

Chairman JACOBS. In order to do well.

Any further questions?

[No response.]

Chairman JACOBS. We thank the General Accounting Office for its usual sterling performance.

Mr. Richard Kusserow, Inspector General for the Department of Health and Human Services, is our next witness.

**STATEMENT OF RICHARD P. KUSSEROW, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY LARRY SIMMONS, DEPUTY ASSISTANT INSPECTOR GENERAL FOR AUDITING; TONY SCHUMACHER, AUDITOR; AND DON WHALEN, KANSAS CITY REGIONAL OFFICE**

Mr. KUSSEROW. Thank you, Mr. Chairman.

Mr. Chairman and members of the subcommittee, I am Richard Kusserow, Inspector General of the Department of Health and Human Services. With me today on my immediate right is Larry Simmons, who heads up our HCFA Audit Division. To my left is Tony Schumacher, and on my far right, Don Whalen out of our Kansas City Regional Office, who took the lead in the study in this area.

We are pleased to appear today to discuss the involvement of the Office of Inspector General in determining the impact of mergers and acquisitions of medical facilities on medicare and medicaid costs and evaluating the adequacy of the Medicare regulations and guidelines in this area.

The testimony today will discuss our involvement from the prospective of our continuing audit interest in this area. Mr. Chairman, with your permission, I would like to abbreviate portions of my testimony to allow as much time for questioning as is possible.

Chairman JACOBS. That goes without saying, sir. That is always allowable.

Mr. KUSSEROW. I will submit the full text for the record.

As you know, Mr. Chairman, the medicare program at the present time and the medicaid program in many States reimburse hospitals and nursing homes on a cost-reimbursement basis for depreciation, interest expense, and in the case of proprietary providers, return on equity. These costs, referred to as the capital costs, relate to buildings as well as building service equipment, that is, installed or fixed equipment, such as elevators, boilers, air conditioning equipment, as well as movable equipment, beds, chairs, and so forth. When these facilities are sold at more than book value—the undepreciated cost at the time of sale—capital costs, and conse-

quently the costs of the medicare program and in many States the medicaid program, increase.

We have for several years been concerned about the frequent sale of hospitals and nursing homes. These sales have an effect on increasing costs of the medicare and medicaid programs without a commensurate increase in the quality of facilities or quantity of the services.

This is in contrast to hospitals and nursing homes which are not sold. In these cases, the hospitals and nursing homes are locked into the original costs for medicare and medicaid program reimbursement purposes, except, of course, when they are expanded or reconstructed. While construction adds to the industry in terms of new buildings, equipment, and technology, sales generally only increase the cost of the existing facilities.

In our preliminary work, we wanted to identify the magnitude of mergers and acquisitions. To do this, we focused on hospital acquisitions by six major proprietary chain corporations during the period 1967 through 1983, and this information is depicted on chart 1. As you can see, the number of acquisitions was considerable, especially since 1978.

We also wanted to identify the effect of mergers and acquisitions on medicare and medicaid program costs. To do this, we reviewed specific hospital and nursing home sales transactions at two medicare intermediaries and two medicaid State fiscal agents. The hospital sales at two medicare intermediaries during the period 1979 through 1981 are summarized on chart 2. As you can see, the average selling price exceeded the seller's average undepreciated cost by a considerable amount, from 91 to 171 percent.

Chart 3 summarizes sales of nursing homes at the two medicaid State fiscal agents during the period 1978 through 1982. Again, the average selling prices considerably exceed the seller's average undepreciated cost, from 32 percent to 149 percent.

Although the prices paid for the nursing homes was not as large as for the hospital, the increases are just as dramatic. Also it is worth noting that for both hospitals and nursing homes, the average selling price increased significantly each year. Although the above increases are dramatic, they do not show the full effect of the cost increases to the medicare and medicaid programs.

This is because capital cost increases not only affect the amounts charged for annual depreciation, but increased as well are the financing charges associated with higher costs, interest costs if the funds were borrowed, and the return on equity if the funds were invested.

Our detailed review of several transactions to date illustrate the full impact sales had on medicare and medicaid costs.

Now, chart 4 shows the capital cost per patient day and the total medicare costs for two hospitals before and after sale. As you can see, the capital cost per patient day increased from $32.81 to $102.32, or 212 percent at hospital A, while at hospital B the capital costs per patient day increased from $31.79 to $115.08, or 262 percent.

The total medicare costs at the two hospitals increased $5.3 million and $1.5 million, respectively, after sale, and most of the increases, over 70 percent, resulted from increased capital costs.

Similarly, chart 5 will show that the capital cost portion of the per diem rate before and after sale for three medicaid nursing homes as is shown there, these costs increased from $3.17 to $7.39 or from, again, 67 percent to 591 percent.

At the present time, medicare regulations contain several provisions which address the sale of hospital and nursing home facilities. One provision requires that when facilities—building, and equipment—are sold, intermediaries are to limit the new cost basis to the lower of fair market value or current reproduction costs adjusted for straight line depreciation to time of purchase.

Current reproduction cost is defined as the cost at current prices in a particular locality or marketplace of reproducing the facility in kind.

Our preliminary work shows that at least one problem exists in this area. That is, intermediaries are relying on appraisals obtained by buyers to establish the cost basis of facilities after sale. As a result, a portion of the costs may be unallowable or at least questionable for medicare and medicaid reimbursement.

The significance of this problem is illustrated by a review of seven hospital sales. For these sales, the appraised value exceeds depreciated reproduction costs by about $27 million or 30 percent. The appraised values were higher because, one, four appraisals used current hospital square feet requirements rather than the actual square footage of the purchased hospitals to compute the reproduction costs.

Second, five appraisals used a 50-year lifespan for buildings and building service equipment to determine depreciated costs.

Third, one appraisal was revised to transfer 50 percent of the building service equipment value to the cost of the buildings.

Fourth, one appraisal increased the value of a hospital by $1.4 million, or about 9 percent, on the basis that the buyer had higher quality construction standards than that of the facilities purchased.

Medicare regulations, in some States medicaid regulations, also provide that when facilities, buildings, and equipment are sold for more than book value, the medicare and medicaid programs are entitled to a portion of the gain. The portion of the gain is based on the amount of depreciation previously claimed for medicare and medicaid reimbursement. Any financing charges previously claimed by the seller, however, are not subject to recovery.

Our preliminary work at two medicare intermediaries shows that although portions of the gains were recovered when the facilities were sold, the recoveries usually did not occur until from 1 to 3 years after the sale. Consequently the value of the recoveries due to the time value of the money was substantially less than the actual payments to the providers.

Also we noted that some intermediaries were not recovering the full portion of the gain attributable to the medicare program. Specifically, intermediaries were allowing providers to retroactively adjust their equity capital for the nonmedicare depreciation applicable to the gain. This increased the return on equity payment to the provider, thereby reducing the recovery to the medicare program.

We estimate that the recoveries due to the medicare program from one proprietary chain corporation alone may have been im-

properly reduced by as much as $13.5 million. We did not determine the effect of these reductions on the recoveries to the medicaid program.

At the two medicaid State fiscal agents, we found that one did not implement a provision until 1982 for sharing in gains when nursing homes were sold. The other fiscal agent established a provision effective in 1977 for sharing in gains for nursing home sales but only if the sale occurred within ten years after construction or prior sale. Consequently, at the time of our review, these fiscal agents recovered only $14,000 of the gain of $19.6 million relating to nursing home sales, as indicated on chart 3.

On September 12, 1983, we issued a preliminary report to the Health Care Financing Administration and the Assistant Secretary for Planning Evaluation entitled "Limiting Depreciation Base When Medical Facilities are Sold with Substantially Reduced Capital Cost Increases to the Medicare/Medicaid Programs," and, Mr. Chairman, with your permission, I would be happy to submit that for the record.

Chairman JACOBS. Without objection.

Mr. KUSSEROW. The purpose of the report was to draw attention to the problem of rapidly increasing capital costs, especially in light of the requirement in Public Law 98-21 for proposed methods for incorporating capital costs into the medicare hospital prospective payment system.

In addition to matters highlighted above, the report discussed reimbursement systems used by four States to control capital cost increases under the medicare/medicaid program. Two States used prospective payment systems to control cost increases.

Now, chart 6 compares the capital costs and the operating costs for nursing homes sold in one of these States during the period 1980 through 1982 to nursing homes which were not sold. As shown on the chart, the average capital cost portion of the per diem costs for nursing homes which were sold was $2.49 or 87 percent higher than the average for nursing homes not sold.

However, the average total per diem cost for nursing homes which were sold was only $1.25 or 5 percent higher than the average for those homes not sold. Consequently, much of the capital cost increase was absorbed by reduction in nursing home operating costs.

Although the primary purpose of this hearing is to obtain comments on the effect of mergers and acquisitions on medicare and medicaid program costs, we believe that a related matter also needs attention. This matter is the persistent problem of overconstruction of hospital facilities.

An audit of the certificate of need program recently completed by us shows that the construction of unnecessary hospital facilities over the last 10 years has continued notwithstanding the efforts of States to control them. Unnecessarily facilities also increase capital costs and consequently the cost of medicare and medicaid programs.

This problem in our opinion must also be addressed by the Department in developing its legislative proposals for including capital costs in the medicare prospective payments system. We estimate that excess hospital beds are currently costing consumers

about $2.9 billion annually. Chart 7 shows the number of excess hospital beds and the cost to maintain them.

One additional matter the subcommittee may want to consider is whether medicare and medicaid should reimburse providers for depreciation on assets financed with Federal funds. HCFA's policy of reimbursing depreciation claimed on federally financed assets results in the Federal Government paying for health facilities twice, once for a direct grant and again as a medicare or medicaid cost.

We estimate that the elimination of the depreciation charges on assets financed with the Hill-Burton grants alone would save medicare or medicaid over $720 million.

In summary, I would like to state that we share the subcommittee's concern over the impact of mergers and acquisitions on the medicare and medicaid programs. We believe that this matter is particularly important since Public Law 98–21 requires the Department to report to the Congress in October 1984 on ways in which to include capital costs in the medicare prospective payment system.

To assist the Department in this task, we have a number of audits planned or in process. These audits deal with matters discussed above, as well as others which we believe are relevant to the subject of mergers and acquisitions. They include:

One, determining the extent to which gains on the sale of assets are being recovered by medicare and medicaid;

Second, evaluating the propriety of cost basis to assign to assets after sale;

Third, determining whether the consequences of taxes should be considered in reimbursing providers for capital costs;

Fourth, evaluating the need to reimburse providers for return on equity;

Five, developing a conceptual framework for incorporating capital costs in the medicare prospective payment system.

Mr. Chairman, this concludes our formal statement. We stand ready to answer any questions that you or the committee might have.

[The prepared statement and report referred to follow:]

STATEMENT OF RICHARD P. KUSSEROW, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairmen and members of the Subcommittees, we are pleased to appear today to discuss the involvement of the Office of Inspector General's Office of Audit in determining the impact of mergers and acquisitions of medical facilities on Medicare and Medicaid program costs and in evaluating the adequacy of the Medicare regulations and guidelines in this area. The testimony today discusses our involvement from the perspective of our continuing audit interest in this area.

As you know, the Medicare program, at the present time, and the Medicaid program, in many states, reimburse hospitals and nursing homes on a cost reimbursement basis for depreciation, interest expense, and, in the case of proprietary providers, return-on-equity. These costs, referred to as Capital Costs, relate to buildings as well as building service equipment (installed or fixed equipment such as elevators, boilers, air conditioning equipment, etc.) and movable equipment (beds, chairs, etc.). When these facilities are sold at more than book value (undepreciated cost at the time of sale) capital costs and, consequently, the costs to the Medicare program and, in many states, the Medicaid program increase.

The Office of Audit has, for several years, been concerned about the frequent sales of hospitals and nursing homes. These sales have the effect of increasing costs to the Medicare and Medicaid programs without a commensurate increase in the quality of facilities or the quantity of services. This is in contrast to

hospitals and nursing homes which are not sold. In these cases, the hospitals and nursing homes are locked into their original costs for Medicare and Medicaid program reimbursement purposes except, of course, when they are expanded or reconstructed. While construction adds to the industry in terms of new buildings, equipment, and technologies, sales generally only increase the cost of existing facilities.

In our preliminary work we wanted to identify the magnitude of mergers and acquisitions. To do this we focused on hospital acquisitions by six major proprietary chain corporations during the period 1967 through 1983. This information is shown on Chart I. As you can see, the number of acquisitions was considerable, especially since 1978.

We also wanted to identify the effect of mergers and acquisitions on Medicare and Medicaid program costs. To do this, we reviewed specific hospital and nursing home sales transactions at two Medicare intermediaries and two Medicaid state fiscal agents. The hospital sales at the two Medicare intermediaries during the period 1979 through 1981 are summarized on Chart II. As you can see, the average selling prices exceeded the sellers' average undepreciated cost by a considerable amount--from 91 to 171 percent. Chart III summarizes sales of nursing homes at the two Medicaid state fiscal agents during the period 1978 through 1982. Again, the average selling prices considerably exceed the sellers' average undepreciated costs--from 32 to 149 percent.

And, although the prices paid for the nursing homes were not as large as for hospitals, the increases are just as dramatic. Also, it is worth noting that for both hospitals and nursing homes, the average selling price has significantly increased.

Although the above increases are dramatic, they do not show the full effect of the cost increases to the Medicare and Medicaid programs. This is because capital cost increases not only effect the amounts charged for annual depreciation, but the financing charges associated with higher costs are increased as well--interest costs if the funds were borrowed and return-on-equity if the funds were invested.

Our detailed review of several transactions to date illustrate the full impact sales had on Medicare and Medicaid program costs. Chart IV shows the capital cost per patient day and total Medicare costs for two hospitals before and after sale. As you can see, the capital costs per patient day increased from $32.81 to $102.32, or 212 percent, at hospital A while at hospital B the capital costs per patient day increased from $31.79 to $115.08, or 262 percent. Total Medicare costs at the two hospitals increased $5.3 million and $1.5 million respectively after sale. And, most of the increases--over 70 percent--resulted from increased capital costs.

Similarly, Chart V shows the capital cost portion of the per diem rate before and after sale for three Medicaid nursing homes. As shown, these costs increased from $3.17 to $7.39, or from 67 to 591 percent.

At the present time, Medicare regulations contain several provisions which address the sale of hospital and nursing home facilities. One provision requires that when facilities (buildings and equipment) are sold, intermediaries are to limit the new cost basis to the lower of fair market value or current reproduction cost adjusted for straight-line depreciation to time of purchase. Current reproduction cost is defined as the cost at current prices, in a particular locality or market place, of reproducing the facility in kind. Our preliminary work shows that at least one problem exists in this area. That is, intermediaries are relying on appraisals obtained by buyers to establish the cost basis of facilities after sale. As a result, a portion of the cost may be unallowable or at least questionable for Medicare and Medicaid reimbursement. The significance of this problem is illustrated by our review of seven hospital sales. For these sales, the appraised values exceeded depreciated reproduction costs by about $27 million, or 30 percent. The appraised values were higher because:

-- Four appraisals used current hospital square feet requirements rather than the actual square footage

of purchased hospitals to compute reproduction costs. This increased the value of the hospitals $16 million--17 to 39 percent per hospital. Other appraisals used actual square feet to compute reproduction costs. Appraisals from one company used actual square feet in one instance and current hospital requirements in others.

-- Five appraisals used a 50-year life for buildings and building service equipment to determine depreciated reproduction costs. The 50-year life was used instead of the lesser life previously used or allowed for Medicare purposes. This increased the value of the hospitals from 7 to 15 percent. Other appraisals used 40-year lives or less to depreciate building service equipment.

-- One appraisal was revised to transfer 50 percent of the building service equipment value to the cost of the building. Since the depreciable life is longer for buildings, the combined cost basis of the building and building service equipment was increased by 6 percent.

-- One appraisal increased the value of a hospital by $1.4 million or about 9 percent, on the basis that the buyer had higher quality construction standards than that of the facility purchased.

We also noted other conditions such as: the years used to depreciate reproduction cost in several appraisals was less than the facilities age, or varied between building and building service equipment without explanation; not all reproduction costs were depreciated; an appraiser used data obtained from a subsidiary of the buyer to estimate construction costs; an appraiser stated that an estimated cost for "Certificate of Need" 1/ was included; or appraisals were made after the purchase date, which make accuracy of the cost basis of the facilities appear questionable if based on the appraisals.

Medicare regulations and, in some states, Medicaid regulations also provide that when facilities (buildings and equipment) are sold for more than book value, the Medicare and Medicaid programs are entitled to a portion of the gain. The portion of the gain is based on the amount of depreciation previously claimed for Medicare and Medicaid reimbursement. Any financing charges previously claimed by the seller, however, are not subject to recovery. Our preliminary work at two Medicare intermediaries

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1/ A "Certificate of Need" is, in effect, a license issued by the applicable state and is necessary to operate a hospital or nursing home. Because it is a license the cost associated with it would be an intangible asset and not reimbursable under the Medicare or Medicaid programs.

showed that although portions of the gains were recovered when facilities were sold, the recoveries usually did not occur until from 1 to 3 years after sale. This was because of (1) delays in getting the final cost reports, (2) the need to perform a final audit, or (3) the time required for HCFA to decide whether the transaction was actually a sale or stock acquisition. (No recovery occurs in the latter instances because there is no write-up of the assets.) Consequently, the value of the recoveries--due to the time value of money--was substantially less than the actual payments to the providers.

Also, we noted that some intermediaries were not recovering the full portion of the gain attributable to the Medicare program. Specifically, intermediaries were allowing providers to retroactively adjust their equity capital for the non-Medicare depreciation applicable to the gain. This increased the return-on-equity payments to the providers thereby reducing the recovery to the Medicare program. We estimate that the recoveries due the Medicare program from one proprietary chain corporation alone may have been improperly reduced by as much as $13.5 million. We did not determine the effect of these reductions on the recoveries due the Medicaid program.

At the two Medicaid state fiscal agents, we found that one did not implement a provision until 1982 for sharing in gains when nursing homes were sold. The other fiscal agent established a provision effective 1977 for sharing in gains for nursing home

sales but only if the sale occurred within 10 years after construction or prior sale. Consequently, at the time of our review, these fiscal agents recovered only $14,000 of the gains of $19.6 million relating to the nursing home sales on Chart III.

On September 12, 1983, we issued a preliminary report to HCFA and the Assistant Secretary for Planning and Evaluation entitled "Limiting the Depreciation Base When Medical Facilities are Sold Would Substantially Reduce Capital Cost Increases to the Medicare and Medicaid Programs." The purpose of the report was to draw attention to the problem of rapidly increasing capital costs, especially in light of the requirement in P.L. 98-21 for the Department to propose methods for incorporating capital costs into the Medicare hospital prospective payment system.

In addition to matters highlighted above, the report discussed reimbursement systems used by four states to control capital cost increases under the Medicaid program. These systems range from prospective payment systems to limiting increases in the cost basis of the facilities after sale.

Two states used prospective payment systems to control cost increases. These so-called prospective payment systems are actually maximum rate systems. That is, payments to nursing homes--referred to as per diem rates--are limited to actual

nursing home costs up to a maximum amount, or maximum rate. However, the maximum rates are periodically adjusted upward based on increases in actual costs.

Theoretically, prospective payment systems should limit significant cost increases, or at least delay them for awhile. However, our review in one state showed they did not limit most capital cost increases. This is because the per diem rates for the nursing homes which were sold were generally lower than the maximum rate. And, although the rates increased after sale because of higher capital costs, the portion of the rates applicable to other operating costs usually remained the same or decreased. Consequently, most of the capital cost increases were paid.

Chart VI compares the capital costs and operating costs for nursing homes sold in one state during the period 1980 through 1982 to nursing homes which were not sold. As shown on the Chart, the average capital costs portion of the per diem costs for nursing homes which were sold was $2.49, or 87 percent, higher than the average for nursing homes not sold. However, the average total per diem costs for nursing homes which were sold was only $1.25, or 5 percent, higher than the average for those homes not sold. Consequently, much of the capital cost increase was absorbed by reductions in nursing home operating costs.

In addition, it is important to note that maximum rates are set periodically based on the range of actual per diem costs. Because nursing home sales increase costs, the range of per diem costs and, consequently, the maximum rates are eventually increased. Therefore, capital cost increases, even if they result in total per diem costs above current maximum rates, may be reimbursed in future periods due to subsequent rate increases.

We also noted that most of the nursing homes sold in the two states were acquired by proprietary chain organizations. At the time of our review, proprietary chains owned or controlled 30 to 47 percent of the nursing homes in the two states. The per diem costs for most proprietary nursing homes were near or above the maximum rates. Accordingly, the acquisition of a majority of the homes by chain organizations--if cost increases continue--could raise the maximum rates significantly.

Two other states used systems which do not consider selling price increases in establishing the cost basis of facilities after sale. Rather, costs are based on the facility's book value or to a "class" base period cost as of some point in time.

The rationale used by one of these two states in establishing their system was as follows:

1. The cost of a facility should be recovered only once.

2. Reimbursement should be reasonably related to the delivery of health care services and not be dependent upon real estate transactions and changes of ownership.

3. Excessive profits should be eliminated, particularly where they are totally unrelated to the improvement of either the quality or quantity of health care services delivered.

4. Similar facilities should receive similar reimbursement without regard to the nature of ownership or subsequent transfers.

5. Delivery of health care is not served by inducing, through the potential of economic gain, frequent transfers of health care facilities.

Some argue that systems such as the latter have a considerable deleterious effect on patient access to health care as well as the quality of care. While we did not review either of these systems in detail, we believe those concerns may be exaggerated. For one thing, many hospitals and nursing homes have not experienced changes in ownership and, consequently, are tied to their original cost. And, new facilities continue to be constructed. These facilities are reimbursed on the basis of

actual cost. It appears to us that the majority of the providers affected by limiting cost increases when facilities are sold would be proprietary providers and only then when facilities are sold.

Although the primary purpose of this hearing is to obtain comments on the effects of mergers and acquisitions on Medicare and Medicaid program costs, we believe a related matter also needs attention. This matter is the persistent problem of overconstruction of hospital facilities. Information gathered by my office on the "Certificate of Need" program shows that the construction of unnecessary hospital facilities over the last 10 years has continued notwithstanding the efforts of States to control them. Unnecessary facilities also increase capital costs and, consequently, the costs to the Medicare and Medicaid programs. This problem, in our opinion, must also be addressed by the Department in developing its legislative proposals for including capital costs in the Medicare prospective payment system. We estimate that excess hospital beds are currently costing consumers about $2.9 billion annually. Chart VII shows the number of excess hospital beds and the annual cost to maintain them.

One additional matter the Subcommittees may want to consider is whether Medicare and Medicaid should reimburse providers for depreciation on assets financed with Federal funds. HCFA's policy of reimbursing depreciation claimed on Federally financed

assets results in the Federal Government paying for health facilities twice--once as a direct grant and again as a Medicare or Medicaid "cost". We estimate that the elimination of depreciation charges on assets financed with Hill-Burton grants alone could save Medicare and Medicaid over $720 million.

In summary, I would like to state that we share the Subcommittees' concern over the impact of mergers and acquisitions on the Medicare and Medicaid programs. We believe that this matter is particularly important since P.L. 98-21 requires the Department to report to the Congress by October 1984 on ways in which to include capital costs in the Medicare prospective payment system. To assist the Department in this task, we have a number of audits planned or in process. These audits deal with matters discussed above as well as others which we believe are relevant to the subject of mergers and acquisitions. They include:

1. Determining the extent to which gains on the sale of assets are being recovered by Medicare and Medicaid.

2. Evaluating the propriety of the cost basis assigned to assets after sales.

3. Determining whether the consequences of taxes should be considered in reimbursing providers for capital costs.

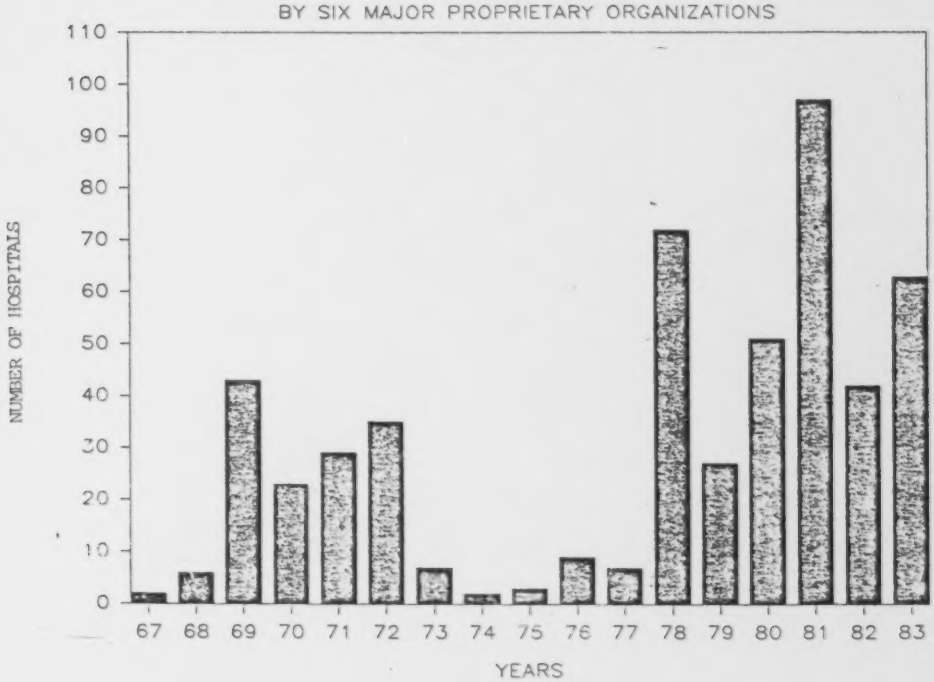
4. Evaluating the need to reimburse providers for return on equity.

5. Developing a conceptual framework for incorporating capital costs in the Medicare prospective payment system.

This concludes my testimony. I am ready to answer any questions you may have.

# HOSPITAL ACQUISITIONS 1967–1983

BY SIX MAJOR PROPRIETARY ORGANIZATIONS




Total Acquisitions, 1967-1983 518

Total Acquisitions, 1978-1983 352

NOTES:

All acquisitions may not be identified.

Number of acquisitions not complete for 1983.

CHART I

HOSPITAL ACQUISITIONS
BY
PROPRIETARY ORGANIZATIONS

| YEAR | NUMBER OF SALES | AVERAGE SELLERS' UNDEPRECIATED COST | AVERAGE SELLING PRICE | AVERAGE COST INCREASE AMOUNT | AVERAGE COST INCREASE PERCENT |
|---|---|---|---|---|---|
| 1979 1/ | 3 | $ 3,353,000 | $ 6,399,100 | $ 3,046,100 | 91 |
| 1980 2/ | 4 | $ 3,906,800 | $ 10,598,900 | $ 6,692,100 | 171 |
| 1981 2/ | 14 | $ 7,003,000 | $ 14,942,900 | $ 7,939,900 | 113 |

1/ Sales at one intermediary.

2/ Sales at two intermediaries.

CHART II

NURSING HOME ACQUISITIONS

BY

PROPRIETARY ORGANIZATIONS

| YEAR | NUMBER OF SALES | AVERAGE SELLERS' UNDEPRECIATED COST | AVERAGE SELLING PRICE | AVERAGE COST INCREASE AMOUNT | AVERAGE COST INCREASE PERCENT |
|---|---|---|---|---|---|
| 1978 1/ | 3 | $499,629 | $ 659,383 | $159,754 | 32 |
| 1979 1/ | 3 | $281,618 | $ 493,167 | $211,549 | 75 |
| 1980 2/ | 14 | $399,290 | $ 844,929 | $445,640 | 112 |
| 1981 2/ | 18 | $496,125 | $1,122,984 | $633,859 | 128 |
| 1982 2/ | 32 | $531,262 | $1,321,491 | $790,229 | 149 |

1/ Sales in one State.

2/ Sales in two States.

CHART III

CAPITAL COST INCREASES
HOSPITAL

| | YEAR BEFORE SALE | YEAR AFTER SALE | INCREASES AMOUNT | INCREASES PERCENT |
|---|---|---|---|---|
| HOSPITAL A | | | | |
| Capital Costs Per Patient Day | $ 32.81 | $ 102.32 | $ 69.51 | 212 |
| Total Medicare Costs (MILLIONS) | $ 32.4 | $ 37.7 | $ 5.3 | |
| Portion of Medicare Cost Increase Due To Increased Capital Costs (MILLIONS) | | | $ 3.9 | |
| HOSPITAL B | | | | |
| Capital Costs Per Patient Day | $ 31.79 | $ 115.08 | $ 83.29 | 262 |
| Total Medicare Costs (MILLIONS) | $ 6.3 | $ 7.8 | $ 1.5 | |
| Portion of Medicare Cost Increase Due To Increased Capital Costs (MILLIONS) | | | $ 1.1 | |

CHART IV

CAPITAL COST INCREASES
NURSING HOME

| | YEAR BEFORE SALE | YEAR AFTER SALE | INCREASES AMOUNT | INCREASES PERCENT |
|---|---|---|---|---|
| NURSING HOME A | | | | |
| Capital Cost Portion of Per Diem Rate | $ 2.44 | $ 5.83 | $ 3.39 | 139 |
| NURSING HOME B | | | | |
| Capital Cost Portion of Per Diem Rate | $ 4.76 | $ 7.93 | $ 3.17 | 67 |
| NURSING HOME C | | | | |
| Capital Cost Portion of Per Diem Rate | $ 1.25 | $ 8.64 | $ 7.39 | 591 |

CHART V

COMPARISON OF COSTS OF
NURSING HOMES SOLD
TO NURSING HOMES NOT SOLD
FOR PERIOD 1980 THROUGH 1982

| | AVERAGE PER DIEM COSTS FOR NURSING HOMES | | DIFFERENCE | |
|---|---|---|---|---|
| COST ELEMENT | NOT SOLD | SOLD | AMOUNT | PERCENT |
| Capital Costs | $ 2.87 | $ 5.36 | $ 2.49 | 87 |
| Operating Costs | 24.51 | 23.27 | ( 1.24) | ( 5) |
| Total | $ 27.38 | $ 28.63 | $ 1.25 | 5 |

CHART VI

ANNUAL COST OF MAINTAINING
EXCESS HOSPITAL BEDS

| STATE 1/ | 1981 BEDS/1,000 2/ | 1981 EXCESS BEDS | ANNUAL COST TO MAINTAIN EXCESS BEDS 3/ |
|---|---|---|---|
| Alabama | 4.8 | 3174 | $ 103,107,390 |
| Arkansas | 4.7 | 1572 | 51,066,420 |
| Florida | 4.6 | 6274 | 203,810,890 |
| Georgia | 4.1 | 542 | 17,606,870 |
| Illinois | 4.8 | 9456 | 307,178,160 |
| Indiana | 4.3 | 1861 | 60,454,585 |
| Iowa | 5.2 | 3458 | 112,333,130 |
| Kansas | 5.4 | 3265 | 106,063,525 |
| Kentucky | 4.1 | 434 | 14,098,490 |
| Louisiana | 4.5 | 2072 | 67,308,920 |
| Maine | 4.1 | 78 | 2,533,830 |
| Massachusetts | 4.4 | 2192 | 71,207,120 |
| Michigan | 4.2 | 1814 | 58,927,790 |
| Minnesota | 4.8 | 3146 | 102,197,810 |
| Mississippi | 4.9 | 2158 | 70,102,630 |
| Missouri | 5.3 | 6112 | 198,548,320 |
| Montana | 4.1 | 114 | 3,703,290 |
| Nebraska | 5.4 | 2249 | 73,058,765 |
| New York | 4.4 | 6455 | 209,690,675 |
| North Dakota | 5.8 | 1193 | 38,754,605 |
| Ohio | 4.6 | 6384 | 207,384,240 |
| Oklahoma | 4.1 | 436 | 14,163,460 |
| Pennsylvania | 4.6 | 7520 | 244,287,200 |
| South Dakota | 5.1 | 779 | 25,305,815 |
| Tennessee | 5.2 | 5674 | 184,319,890 |
| Texas | 4.3 | 4271 | 138,743,435 |
| West Virginia | 5.0 | 2024 | 65,749,640 |
| Wisconsin | 4.4 | 1698 | 55,159,530 |
| Washington, D.C. | 7.4 | 2129 | 69,160,565 |
| Totals | | 88,534 | $2,876,026,990 |

1/ Represents those states with excess beds based on standard or ceiling of 4.0 beds per 1,000 population.

2/ Based on staffed and set-up beds as reported by the AHA and population estimates by the Census Bureau.

3/ Represents total cost to public computed as follows: Excess Beds x 365 x Semi-private Room Charge ($178) x 50% = Annual Cost to Maintain.

CHART VII

# OIG OFFICE OF AUDIT
# KANSAS CITY REGIONAL OFFICE
# PRELIMINARY AUDIT REPORT

# LIMITING THE DEPRECIATION BASE WHEN MEDICAL FACILITIES ARE SOLD WOULD SUBSTANTIALLY REDUCE CAPITAL COSTS INCREASES TO THE MEDICARE AND MEDICAID PROGRAMS

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT

Audit Control Number 07-32006

35-141 O - 84 - 5

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

# Memorandum

Date SEP 12 1986

From /s/ Richard P. Kusserow
Richard P. Kusserow
Inspector General

Subject Preliminary OIG Audit Report - Limiting the Depreciation Base When Medical Facilities are Sold Would Substantially Reduce Capital Cost Increases to the Medicare and Medicaid Programs (Audit Control Number 07-32006)

To Carolyne K. Davis, Ph.D.
Administrator, Health Care Financing Administration

Attached is a preliminary report prepared by our Kansas City Regional Inspector General for Audit. It summarizes the results of his limited review of certain capital costs -- depreciation and interest expense -- reimbursed under Medicare and Medicaid.

The preliminary report discusses a number of considerations related to capital costs. But, its major point is that purchases of used medical facilities are usually made at prices far in excess of the sellers' book values of those assets -- and often even in excess of the sellers' acquisition costs -- resulting in subsequent higher costs to all parties purchasing care at those facilities. It also discusses policies adopted by two States which limit Medicaid's recognition of such increases in capital costs.

HCFA has recently embarked on a study, mandated by P.L. 98-21, of how to incorporate capital costs into the hospital prospective payment system. We believe the material in this preliminary report is pertinent to the overall consideration of that subject. So, we are sending it to you at this time even though no recommendations have been developed. However, we do recommend that your staff consider this material in its overall study of Medicare (and Medicaid) reimbursement for capital costs.

Finally, the preliminary report contains an Appendix which proposes additional work to better develop the conditions described in the body of the report. We request your views on the proposed effort and on other work we might undertake which could help HCFA in its current study. Naturally, we would appreciate any other comments you may wish to offer.

Attachment

## INTRODUCTION

This preliminary report summarizes the results of our limited review of capital costs reimbursed under the Medicare and Medicaid programs. Our review was performed to determine the extent to which the sales of medical facilities increased capital costs and whether the increased costs were necessary. We reviewed information available on selected sales from 1977 through 1982 at one Medicare intermediary and two Medicaid state agencies. In addition, we reviewed systems implemented by two states to control capital costs.

Our review results show that the gains on sales of medical facilities over the past several years have had and will continue to have a substantial effect on the amount of capital costs reimbursed under the Medicare and Medicaid programs. For example, sales during the period 1977 through 1982 at the one intermediary and two state Medicaid agencies reviewed will increase Medicare and Medicaid (Federal share) program payments by about $218 million over the depreciable life of the facilities. These sales resulted in substantial profits to the sellers and increased cash flow (through charges for depreciation) to the buyer but did not increase the quantity or quality of health care. One important reason for this, in our opinion, is that Medicare and, in many states, Medicaid program reimbursement policies do not restrict--and in fact may even encourage--the growth in capital costs.

BACKGROUND

Capital costs consist primarily of depreciation and interest expense. Other items, such as property taxes (for profit providers only) and insurance, are also defined as capital costs. However, because the latter costs are relatively minor, we did not include them in our review.

Currently, under the Medicare and, in many states, the Medicaid program depreciation is reimbursed as an allowable expense. According to program regulations, depreciation is intended to allocate costs over the estimated useful life of the facilities. These regulations also provide that when facilities are sold for more than their book value, depreciation claimed for Medicare and Medicaid program purposes representing the difference between the book value and selling price--up to the original acquisition cost--must be refunded or the new depreciation base reduced by the amount of depreciation previously reimbursed. However, if the facility sold has been leased for more than one year, depreciation applicable to a gain on sale is not recovered.

Interest expense, as well as other capital costs, is an allowable expense under the Medicare and Medicaid programs. These expenses are not subject to recovery when facilities are sold at a gain. Reimbursement of interest expense on a facility's debt is limited to the facility cost allowable in the depreciation base.

## PRELIMINARY FINDINGS

### SALES OF MEDICAL FACILITIES

Our review, which included Medicaid providers in Nebraska and Iowa and Medicare providers served by Mutual of Omaha, showed that most facilities sold during the period 1977 through 1982 were sold at prices which were equal to or, more often, exceeded original acquisition cost. Consequently, no "depreciation" occurred. In effect, the payment of depreciation in the above situations resulted in interest-free loans to facility owners. And, even if the depreciation is subsequently recovered, the interest cost incurred by the Federal government can be substantial, possibly as much as the depreciation recovered. Further, depreciation not recovered is reflected in the new depreciation base and will be reimbursed again.

Of greater significance, the sales with large gains substantially increase future costs to the Medicare and Medicaid programs, as well as private pay patients, with no increase in medical benefits or services. The sales usually result only in continued operation of existing facilities but at a much higher cost. Most sellers and buyers of the medical facilities were proprietary, many of which were chain organizations.

#### Medicare Facilities

At one Medicare intermediary (Mutual of Omaha), our review of sales from 1977 through 1981 showed that 18 of 21 hospital sales and all nursing home sales resulted in gains. Since 1979 all hospitals were sold at a gain and in all but one instance, the

selling price exceeded the original acquisition cost plus improvements. The total gain on sales was about $112.5 million; $80.2 million was the gain over the original cost, and $32.3 million was the difference between book value and original acquisition cost.

The average gain per hospital by year is shown in the following table.

| Year | Average Original Acquisition Cost | Average Gain (Total) | Average Amount Above Original Acquisition Cost |
|---|---|---|---|
| 1977 | $ 590,500 | $ 1,700 | $ -0- |
| 1978 | 19,736,200 | 383,400 | 227,600 |
| 1979 | 5,850,000 | 3,711,700 | 2,451,100 |
| 1980 | 5,973,600 | 7,459,800 | 6,055,500 |
| 1981 | 8,872,800 | 7,483,300 | 5,198,900 |

The sales related to hospitals located in seven states scattered across the United States.

All nursing home sales resulted in a gain and, in all but one instance, the selling price exceeded the original acquisition cost plus improvements. For the one exception, the gain was only slightly less than the total depreciation claimed. Total gain on the nursing home sales, which involved 15 nursing homes, was $9.1 million, of which $4.6 million represented the gain over original acquisition costs and $4.5 million was the difference between book value and the original acquisition costs.

Mutual generally recovered or adjusted the final cost reports for gains applicable to depreciation reimbursed by Medicare. However, final recovery or adjustment of depreciation usually took from one

to three years because of (1) delays in getting the final cost report, (2) the need to perform a final audit, or (3) the time elapsed for HCFA's determination that the change of ownership was either a sale or a stock acquisition.

Medicaid Facilities

Our review of recent sales of nursing homes in two states--Iowa and Nebraska--showed that the selling prices were higher than the original acquisition cost of the homes plus improvements. In fact, the selling prices averaged about 166 percent of the original acquisition costs plus improvements. The total gain on the sales was about $46.5 million; $32.8 million was the gain over the original cost, and $13.7 million was the difference between the book value of the homes and original cost.

During the period January 1978 through October 1982, 32 ICF nursing homes in Nebraska were sold. In most instances, the nursing homes were sold to proprietary chain organizations. In all instances, the selling prices exceeded original acquisition cost plus improvements by amounts ranging from 113 to 237 percent. The total gain on the 32 sales was about $19.8 million. About $13.9 represented the gain over the original acquisition cost and $5.9 was the difference between book value and original acquisition cost.

During the period March 1979 through November 1982, 43 ICF nursing homes in Iowa were sold. Again, in most instances, the nursing

homes were sold to proprietary chain organizations and the selling prices exceeded original acquisition cost plus improvements. The selling prices of the nursing homes ranged from a little over 100 to 246 percent of original acquisition cost plus improvements. The total gain for the 43 sales was about $26.7 million. About $18.9 million represented the gain over the original acquisition cost and $7.8 million was the difference between the book value and the original acquisition cost.

Information was not available to accurately determine what portion of the $13.7 million gain applicable to depreciation--Nebraska $5.9 million, and Iowa $7.8 million--was reimbursed by the Medicaid program. However, since Medicaid reimburses at least 50 percent of the nursing home costs in both Nebraska and Iowa, we estimate that about $6.8 million (50 percent of the $13.7 million in reimbursement for depreciation) was paid by Medicaid.

Recovery of depreciation reimbursed under the Medicaid program for facilities sold at a gain varies by state. Under Nebraska's limited recovery requirements only about $14,000 of the $5.9 million gain applicable to depreciation had been recovered at the time of our review. For example, a seller of 13 nursing homes had a gain applicable to depreciation of about $3.5 million. None of the $3.5 million was recovered since Nebraska does not recover depreciation on Medicaid facilities owned by the seller for 10 years or more. In 1981, Medicaid reimbursed 38 to 86 percent of costs relating to these nursing homes. Consequently, the $3.5

million gain will be included in the buyer's depreciation base, and a large portion will be charged against the Medicaid program again.

Iowa did not recover any of the depreciation previously reimbursed to the sellers. A method to adjust the buyer's depreciation base for depreciation reimbursed by Medicaid was designed by Iowa in 1980, but it was not fully operational and was not applied to the sales reviewed. However, during 1981/82 Iowa only reimbursed about 60 percent of the depreciation claimed for some nursing homes because of a State funding problem. For years prior to 1981, all depreciation claimed was reimbursed for at least 74 percent of the nursing homes and up to 100 percent for most nursing homes sold.

REASONABLENESS OF SELLING PRICES

Charges for depreciation provide a source of considerable operating cash to buyers of medical facilities. Consequently, the lack of an effective limit on the new depreciation base allowable after sale may encourage buyers to pay more than the replacement cost or actual worth of facilities. This is especially true when the facilities are heavily financed, since most of the debt repayments in the early years apply to financing costs and financing costs are reimbursable. Consequently, the higher the purchase price, the higher the operating cash--or cash flow--to the owners and the higher the costs--depreciation and interest expense--to the Medicare and Medicaid programs.

Also, because the construction of new medical facilities is generally limited to need, a buyer wanting to expand ownership of medical facilities usually has to purchase existing facilities. Sometimes this can only be accomplished by offering attractive prices. However, since continued patient utilization is virtually assured through third party payments--including Medicare and Medicaid--the price paid for medical facilities is inconsequential.

Inflated Selling Prices

During our review, we noted numerous selling prices which appeared to exceed inflation increases or estimated reproduction cost less depreciation. For example, in 1977 two proprietary hospital chain organizations were merged with acquisition costs of about $150 million. In 1981, the merged organization was sold to another proprietary chain organization for approximately $650 million. The sale involved about 150 hospitals, 10 of which were served by Mutual.

Another example was a hospital built in 1976 at a cost of $8.5 million including equipment. This hospital was sold in 1980, after only 4 years, for about $14.6 million. This was an increase of $6.1 million over the original construction costs and $8.1 million over book value. The purchase price of $14.6 million, reported on the buyer's Medicare cost report, was basically supported by an appraisal which valued the land and building at about $13.4 million. The appraisal did not include moveable equipment valued by the buyer at about $1.2 million.

The value was estimated based on the fair market value of the land and the depreciated reproduction cost of the land improvements and buildings. The appraiser defined reproduction costs as "the cost to replace the facilities today in terms of like capacity taking into consideration current hospital costs." The estimated replacement cost was $130 per square foot with total reproduction cost of $14,111,500. This amount was reduced 8 percent to $12,983,000 based on the facility's economic age (4 years) and estimated useful life of 50 years.

The appraisal report indicated that the estimated value of the building was based on current construction requirements rather than on the building purchased, which will be depreciated to the Medicare program. The appraisal report indicated that current hospital requirements necessitated a structure of at least 650 square feet per bed or a total area of 108,500 square feet. Accordingly, 108,500 square feet, rather than the actual square feet (90,700) in the hospital, was multiplied by $130 to estimate the $14,111,500 value. The $130 per square foot construction cost times 90,700 is $11,791,000, a difference of $2,320,500.

In addition, the appraiser based the useful life of the building on 50 years even though it was being depreciated over a 30-year life for Medicare reimbursement purposes. Using a 30-year life rather than 50 would reduce the reproduction cost by 13.3 percent in lieu of the 8 percent used by the appraiser. Consequently,

$11,791,000 times 86.7 percent would be $10,222,800 or $2,760,200 less than the value derived by the appraisal report.

In another instance, we found that the price of 13 nursing homes sold by one proprietary chain organization to another in Nebraska was substantially higher than the reproduction cost computed less depreciation. The buyer initially offered $19.1 million for the 13 nursing homes. During the certificate of need review, required by Section 1122 of the SSA Act, the State denied the certificate. The denial was made because the proposed price exceeded a reasonable selling price of $13.4 million established by the State based on the estimated reproduction cost. The State review indicated that a selling price of $13.4 million would provide the seller a "liberal and fair return".

The buyer, however, appealed the certificate of need denial to the Certificate of Need Appeal Panel. The buyer also lowered the proposed offer by about $2.9 million, or an average of $223,000 per home. The Appeal Panel approved the sale of the nursing homes at the lowered price of $16.3 million and ordered the Department of Health to issue a certificate of need. Accordingly, the purchase price and new depreciation base exceeded the State's computed reproduction cost by $2.9 million.

Increased Cash Flow

Depreciation is a primary source of cash flow since no cash outlay is involved. Consequently, the higher the purchase price, the higher the cash flow, especially if a major portion of the

purchase price is financed. We found that a substantial portion of the purchase price for most nursing home sales 1/ was financed, often with the sellers financing a large portion of the amount. Accordingly, the buyers invested very little equity in the nursing homes. In fact, we found that some nursing home buyers projected negative equities.

Debt financing increases the potential cash flow since most of the debt payments for a number of years will relate to interest expense which is claimable as part of the daily per diem rate. Accordingly, the buyer will receive reimbursement for depreciation in excess of cash expenditures for equity. For example, a buyer who finances $900,000 of the purchase price over a 30-year period would pay $35,777 on the loan principal (under a level payment) during the first 10 years while receiving $300,000 in depreciation on a 30-year straight-line method. The difference represents non-taxable cash flow. This cash could then be drawn out of the nursing home for other purposes or used to pay unallowable costs. Accordingly, the higher the purchase price and the greater the amount financed, the greater the cash flow available. Also, since most nursing homes in the states reviewed were acquired by proprietary chain organizations with limited investments, the accumulated amount of cash flow by owning several homes could be

1/ Information on hospital sales at the intermediary was limited.

substantial. Other possible financial benefits could be achieved through tax savings.

EFFECT OF HIGH SELLING PRICES

High selling prices, regardless of the reasons, not only increase depreciation bases but significantly increase other costs such as interest expense. Accordingly, sales of medical facilities substantially increase future costs to the Medicare and Medicaid programs as well as to private pay patients with no increase in medical benefits or services--only continued operation of existing facilities.

For example, State reviewers projected that the sale of the 13 Medicaid nursing homes previously discussed would increase the following year's Medicaid program costs by about $1.1 million due to the increased depreciation base and interest costs. At least 70 percent of the purchase price was debt financed. The increase occurred even though Nebraska had a prospective reimbursement system. This reimbursement system reduced the full increase by only about $164,000.

A computer analysis of sales and nursing home costs in Iowa indicated that the above example is typical for most sales. We found that, generally, capital costs claimed under Medicaid by nursing homes increased substantially after sale while operating costs did not. For nursing homes sold in Iowa during 1980 and 1981, capital costs averaged about $3.24 of the total per diem costs before sale and $5.64 after sale, an increase of 74 percent.

However, the increase in the total per diem costs was not much higher than the expected inflation increase. (See the appendix for examples of per diem rate increases of nursing homes sold in Iowa).

The following is a comparison of average per diem costs for nursing homes sold during our review period to the average of all other ICF nursing homes in the state for the 1981/82 cost reporting period.

| Cost Element | Nursing Homes Not Sold | Nursing Homes Sold | Difference Amount | Difference Percent |
|---|---|---|---|---|
| Operating Costs: | | | | |
| Administrative | $ 4.15 | $ 4.17 | $ .02 | .5% |
| Room & Board | 9.08 | 8.79 | ( .29) | (3.2) |
| Health Care | 11.28 | 10.31 | ( .97) | (8.6) |
| Sub-Total | $24.51 | $ 23.27 | ($1.24) | (5.1) |
| Property Costs: | | | | |
| Depreciation | $ 1.08 | $ 1.62 | $ .54 | 50.0 |
| Interest | 1.02 | 2.76 | 1.74 | 170.6 |
| Real Estate | .35 | .56 | .21 | 60.0 |
| Property Insur. | .11 | .11 | 0 | 0 |
| Other | .31 | .31 | 0 | 0 |
| Sub-Total | $ 2.87 | $ 5.36 | $ 2.49 | 86.8 |
| Total Per Diem | $27.38 | $ 28.63 | $ 1.25 | 4.6 |

Increased Capital Costs

As a result of the 108 medical facility sales reviewed at the one Medicare intermediary and two State Medicaid agencies, we estimate that the capital costs reimbursed by the Medicare and Medicaid program will increase about $218 million with no real increase in

medical benefits to the programs. The following illustrates the methodology used to estimate the increased costs.

| Type of Facility | Number | Gain on Sales (In Millions) |
|---|---|---|
| Hospitals | 18 | $112.5 |
| Nursing Home - Medicare | 15 | 9.1 |
| - Medicaid (Iowa) | 43 | 26.7 |
| - Medicaid (Nebraska) | 32 | 19.8 |
| | 108 | $168.1 |

In 1981 the Federal government paid 41.7 percent of hospital costs. Accordingly, increased depreciation costs paid under the Medicare and Medicaid programs resulting from gains on the hospital sales will be about $46.9 million ($112.5 million x 41.7%) based on the 1981 average Medicare and Medicaid utilization percents. Also, in 1981 Federal programs paid 30.1 percent of nursing home costs. Similarly, the Federal share of increased depreciation costs paid under the Medicare and Medicaid programs will be about $16.7 million ($55.6 million x 30.1%) -- a total of $63.6 million for both hospitals and nursing homes.

In addition to increased capital costs because of the higher depreciation charges, interest expense will also substantially increase. Generally a major portion of the purchase price was financed. Where specific financing data was available, many buyers financed 90 percent or more of the purchase price. Accordingly, we estimate that about $151.3 million of the gain ($168.1 million x 90%) was financed. And of the amount financed, $57.2 million will be reimbursed by the Medicare and Medicaid

programs. Assuming a 12 percent interest rate and level monthly payments for 30 years, interest expense on the $57.2 million would be about $154.7 million.

Consequently, we estimate that increases in capital costs to the Medicare and Medicaid programs because of the high selling prices will be about $218.3 million ($63.6 million for depreciation and $154.7 million for interest expense). The estimated increase in capital costs is based on the premise that the facilities are not sold again at higher prices and Medicare and Medicaid utilization does not increase. In addition, our review did not include increased capital costs relating to leased facilities. Some of the potential increase could be limited by the state prospective payment systems. However, review of Iowa and Nebraska sales indicated that most capital cost increases were not limited or were only partially limited and then only for a short time.

CONTROL OF INCREASES

Current Medicare reimbursement policies do not effectively control unnecessary capital cost increases. Other than possibly limiting the new depreciation base and related interest expense to the lesser of reproduction cost or purchase price, most gains on sale of medical facilities are included in the new depreciation base.

Systems followed by the two states reviewed also did not effectively control significant capital cost increases. Nebraska performed a Section 1122 review of the sales which generally included various cost feasibility analyses. However, if the State

agency denied a certificate of need because the selling price was excessive and the increased capital costs were unreasonable, the buyer could appeal the decision. When appealed, most certificate denials were overturned by the State Appeal Panel and the purchase price allowed. Iowa performed a Section 1122 review for hospitals but not for nursing homes. The new depreciation base for nursing homes was generally based on the selling price.

Both states also had prospective reimbursement systems (maximum rates) to control Medicaid cost increases. Theoretically, these methods should limit significant increases, or at least delay them for awhile. However, we found that the prospective reimbursement systems in Nebraska and Iowa did not effectively limit most significant capital cost increases or only delayed the increases for a period of time. Nebraska did not implement prospective reimbursement until August 1, 1982. However, Iowa had used a prospective reimbursement system which limited payment at a maximum daily per diem ceiling. Under this system 74 percent of the nursing homes would receive full reimbursement of allowable costs. The maximum payment was normally adjusted each 6 months based on a new ranking of nursing home costs.

The prospective reimbursement methods did not limit most increases because the daily per diem rates of the nursing homes purchased were generally lower than the maximum or median allowable rate. After acquisition, the daily per diem rate for these homes increased to or above the maximum reimbursable rate because of

higher capital costs. The portion of the rates applicable to other operating costs usually remained the same or decreased. Consequently, most of the capital cost increases were paid. Also, the acquisitions affect future increases in the maximum rates. Subsequently, full payment of most capital cost increases would be made.

In addition, most of the nursing homes and hospitals sold were acquired by proprietary chain organizations. Proprietary chains currently own or control about 30 and 47 percent of the ICF nursing homes in Nebraska and Iowa, respectively. The rates of most proprietary chain-owned homes are near or above the maximum allowable. Accordingly, the acquisition of a majority of the homes by chain organizations could raise the maximum rates significantly.

Effective Controls

Some states recognized the need to prevent or control capital cost increases because of inflated selling prices. We made a cursory review of the procedures implemented by two of these states--New York and Illinois--to deal with inflated capital costs. New York's method was promulgated in response to the State's nursing home scandals. Illinois' plan was developed primarily to prevent unwarranted or inflated prices.

The systems implemented by the states limit reimbursement of the capital cost component after sale independent of the method used to reimburse medical facilities' variable or operating costs. But

of greater significance, the systems do not consider selling prices in computing allowable capital costs. Rather, capital costs are limited to the facilities' book value prior to the sale or to "class" base period cost established as of some point in time. Consequently, the maximum rate allowable after sale did not necessarily increase and the purchase price had little effect. Accordingly, these methods made high or inflated selling prices undesirable and generally impractical.

Although the methods reviewed appear to limit significant capital cost increase after sale, we believe that a plan similar to that implemented by New York State in 1976 more effectively controls capital cost increases. This plan limits reimbursement of the capital cost component for both hospitals and nursing homes to the net depreciated book value of the purchased facility rather than the purchase price. In other words, the capital cost component of the reimbursement rate will continue as though there had been no sale. New York's plan also limited the capital cost component if the facility was leased. Prior to the adoption of the plan, the state permitted a provider's capital cost component to include the cost of purchasing the facility or lease costs paid.

Based on our cursory review, it appeared that the New York method would be feasible to administrate. Also, since it applies to both hospitals and nursing homes, uses a facility's records to identify capital costs allowable rather than more subjective averages, group segmentation, etc., and applies to leasing costs, it appears

to be comprehensive. But more importantly, the rationale used by New York for implementing the method illustrates the applicability and need for such a method on a national basis to control unwarranted increases in capital costs. The rationale was as follows:

1. The State should pay for a facility only once.

2. Reimbursement should be reasonably related to the delivery of health care services and not be dependent upon real estate transactions and changes of ownership.

3. Excessive profits should be eliminated, particularly where they are totally unrelated to the improvement of either the quality or quantity of health care services delivered.

4. Similar facilities should receive similar reimbursement without regard to the nature of ownership or subsequent transfers.

5. Delivery of health care is not served by inducing, through the potential of economic gain, frequent transfers of health care facilities.

New York's plan was challenged in U.S. District Court on the claim that the new regulations conflicted with Medicare regulations and therefore violated the supremacy clause and, by limiting the capital component in the reimbursement rate to "net depreciated value," confiscated property without due process of law. The court upheld the State reimbursement system and, in part, provided the following findings related to the points raised by the plaintiffs.

> "As part of their supremacy argument plaintiffs point to the federal regulations for Medicare which do permit reimbursement on the basis of purchase price provided the purchaser can demonstrate that the sale was bona fide and at a price not in excess

of the fair market value. If the Medicare test were to be applied here, presumably the transfer to CCF would have been approved. However, the federal Medicare regulations do not control; they determine merely the maximum reimbursement rates. As indicated earlier, the state was granted the option of providing alternate standards, and it has done so by severely restricting the capital cost component of the reimbursement rate. Having done so with the approval of the Secretary, there is no conflict with federal statute or regulation and, therefore, no violation of the supremacy clause.

Plaintiffs contend that the state regulations cause an unconstitutional taking of their property without just compensation in violation of the fifth and fourteenth amendments. They argue specifically that the regulations effectively prevent the medical center from being sold at its 'fair market value'; that since, for Medicaid reimbursement purposes, only its net depreciated value would be recognized, no prospective purchaser would be willing or able to pay more than the 'net depreciated value'; and that plaintiff, therefore, can only sell the facility at an artificially low price far below either its 'fair market value' or its replacement value.

It has been held-that: Many kinds of legislative and administrative action affect property values, but without some diminution in the owner's right of use, do not constitute a taking within the purvue of the Fourteenth Amendment. 'Chacon v. Granata. 515 F2d 922, 925 (CA5 1975). cert. denied, 423 US 930 (1975).'

Guided by these standards, it is apparent that plaintiffs have not been deprived of their property without due process of law in violation of the fourteenth amendment. As before, plaintiffs have full right to use the medical center property. The challenged regulations impose no direct legal restraint upon the the property or upon its use. There has been no physical entry by the state, no ouster of the owner, no legal interference with plaintiffs' physical use, possession or enjoyment of the medical center, nor any legal interference with the owner's power of disposition of the property. Citing the economic realities in operating hospitals and nursing homes, plaintiffs argue with undoubted accuracy that no purchaser would be willing to pay for the medical center significantly more than what the state would

allow to be amortized through its reimbursement rates, and that by limiting the basis for reimbursement to 'net depreciated value,' the state regulations impose upon plaintiffs a constantly diminishing potential sale price.

Although plaintiffs' economic analysis and predictions may be true, they do not add up to confiscation. Plaintiffs have received over recent years the 'benefits' of having the taxpayers, through the Medicare and Medicaid systems, pay for medical services rendered at the medical center. The 'fair market value' of the center is at least in part a function of its past income and potential future income. That income, in turn, is determined in part by the reimbursement rate allowed by the state. Recognizing that unconscionable profits from pyramiding sales were in the past realized in transfers of nursing homes, New York State intervened to prevent such profiteering at taxpayer expense. It imposed the capital reimbursement limitation, first on nursing homes, and then extended it to hospitals. Having accepted the benefits of governmentally assisted medical programs, plaintiffs now find themselves deprived of a substantial potential profit because the government that initially provided the funds now exerts the inevitable control.

But loss of a potential profit is not confiscation. Much governmental regulation restricts use and ultimately reduces value from what it would otherwise be in a 'free' market. A rezoning of property from one-half to two acre residential reduces its value, and deprives its owner of the opportunity to sell for the more concentrated residential use. But under well established precedents such a rezoning does not constitute confiscation unless it deprives the owner of any use of the property to which it is reasonably adapted.

Plaintiffs may still operate the medical center. They may sell it for a price which would recognize full reimbursement for their own investment. They might sell it for a substantially higher price to another purchaser who did not intend to rely for income upon reimbursement through taxpayer program. Plaintiffs might even sell the property for some use other than providing

> health care. The court recognizes that some of these alternatives may be unrealistic; they may also reflect unwise public policies. The function of this court, however, is not to determine the wisdom of government health programs, of the state's regulations promulgated thereunder, or of the actions taken by the Public Health Council. What the public policy shall be in this area is left, for better or worse, to our legislators and administrators. This court's function is to determine whether the state's regulations violate the Constitution of the United States, the federal statutes, or federal regulations. After due liberation, the court concludes that they do not."

The Illinois plan was also challenged in U.S. District Court and one argument made by the plaintiff was that Illinois had no evidence of inflated transactions. Court findings indicated that testimony of State officials indicated that the State wanted to prevent trafficking in nursing homes, i.e. buying and selling nursing homes as a real estate investment with the State reimbursing much of the expense. The court also found that the experiences of other states sufficiently indicated that a potential for abuse existed in Illinois if they did not adopt their plan. Further, the court stated that Illinois did not have to wait for the problem to develop before taking steps to avert it.

SUMMARY

We believe that high or inflated selling prices for hospitals and nursing homes illustrated by the sales reviewed will continue to occur unless reimbursement of depreciation is limited or eliminated. Based on the estimated increase in capital cost for the limited number of sales reviewed, we believe that implementation of a system which limits reimbursement of capital costs to the seller's net depreciated book value of assets, whether sold

or leased, would eliminate billions of Medicare and Medicaid program costs. Such a system would control unwarranted or inflated selling prices and related capital cost increases which do not increase the quantity or quality of medical services. This system would also eliminate substantial interest costs to the Federal government and administrative costs to Medicare and Medicaid programs for determining new depreciation bases and recovering depreciation from gains.

Further, the approach used by New York to control expenditures of public funds and the cost of services provided taxpayers from non-competitive sources is not a novel idea. For example, the Department of Defense does not allow purchasers of government contractor facilities to increase capital costs for facilities sold at a gain during contract performance periods. Also, some state power regulatory commissions allow only the net depreciable book value of utilities sold in determining rates. This is based on the principle that the rate payers should only pay for the utility company one time.

APPENDIX A

EXAMPLE A

This nursing home was purchased in 1970 at a cost of $606,302 and sold in 1981 for $925,985, a 53 percent increase over the original acquisition cost. About 90.7 percent of the purchase price was debt financed. The following is a breakdown of the nursing home's per diem costs before and after sale.

| Cost Element | Last Cost Report Before Sale | First Cost Report After Sale | Percent of Increase |
|---|---|---|---|
| Operating Costs: | | | |
| Administrative | $ 2.72 | $ 2.34 | (14.0) |
| Room & Board | 7.78 | 8.43 | 8.4 |
| Health Care | 9.87 | 9.15 | ( 7.3) |
| Total | $ 20.37 | $ 19.92 | ( 2.2) |
| Property Costs: | | | |
| Depreciation | 1.01 | 1.86 | 84.2 |
| Interest | 1.05 | 3.40 | 223.8 |
| Taxes | .38 | .47 | 23.7 |
| Other | -0- | .10 | -- |
| Total | 2.44 | $ 5.83 | 138.9 |
| Total Per Diem Cost | $ 22.81 | $ 25.75 | 12.9 |
| Ratio of Property Costs to Total Per Diem Costs | 10.7% | 22.6% | |

EXAMPLE B

This nursing home was purchased in 1977 at a cost of $680,608 and sold in 1981 for $879,500, a 29% increase over original acquisition costs. Approximately 98 percent of the purchase price was financed principally by the seller. The following is a breakdown of the nursing home's per diem costs before and after sale.

| Cost Element | Last Cost Report Before Sale | First Cost Report After Sale | Percent of Increase |
|---|---|---|---|
| Operating Costs: | | | |
| Administrative | $ 3.76 | $ 4.39 | 16.8 |
| Room & Board | 8.00 | 7.01 | (12.4) |
| Health Care | 10.13 | 10.49 | 3.6 |
| Total | $ 21.89 | $ 21.89 | 0 |
| Property Costs: | | | |
| Depreciation | 1.27 | 1.94 | 52.8 |
| Interest | 2.79 | 5.30 | 90.0 |
| Taxes | .69 | .67 | (2.9) |
| Other | 01 | 02 | 100.0 |
| Total | $ 4.76 | $ 7.93 | 66.6 |
| Total Per Diem Cost | $ 26.65 | $ 29.82 | 11.9 |
| Ratio of Property Costs to Total Per Diem Costs | 17.9% | 26.6% | |

EXAMPLE C

This nursing home was built in 1966 at a cost of $691,295, with an addition in 1975. It was sold in 1981 for $1.6 million, a 131 percent increase over original acquisition costs. Approximately 95 percent of the purchase price was financed. The following is a breakdown of the nursing home's per diem costs before and after sale.

| Cost Element | Last Cost Report Before Sale | First Cost Report After Sale | Percent of Increase |
|---|---|---|---|
| Operating Costs: | | | |
| Administrative | $ 3.99 | $ 3.55 | (11.0) |
| Room & Board | 8.81 | 7.60 | (13.7) |
| Health Care | 10.70 | 10.69 | 0 |
| Total | $ 23.50 | $ 21.84 | ( 7.1) |
| Property Costs: | | | |
| Depreciation | .82 | 2.61 | 218 |
| Interest | .15 | 5.35 | 3466 |
| Taxes | .28 | .28 | -0- |
| Other | 0 | .40 | -- |
| Total | $ 1.25 | $ 8.64 | 591.2 |
| Total Per Diem Costs | $ 24.75 | $ 30.48 | 23.2 |
| Ratio of Property Costs to Total Per Diem Costs | 5.1% | 28.3% | |

APPENDIX B

## ADDITIONAL REVIEW

## REVIEW OF CAPITAL COSTS

As a minimum, we believe that work in the following areas is needed to fully develop the condition presented in the proposed preliminary report and to devise a method for projecting potential savings nationally.

1. To provide a broader prospective on volume of medical facility sales and anticipated gains, review sales at two additional major Medicare intermediaries and one large State outside the Region VII. Blue Cross of Tennessee has been tentatively selected as one of the Medicare intermediaries because it services several large proprietary chain organizations and the home office of the Hospital Corporation of America (HCA). Specific information is needed on the HCA sale discussed in the preliminary report.

2. Review nursing home sales in Missouri because (1) reimbursement rates appear substantially out of line with adjoining states in the Region, (2) a significant number of nursing homes are being leased and sub-leased, and (3) Missouri reportedly has the "fastest growing cost of health care in the United States." Based on cursory review, it appears that, in addition to sales, much of the rising costs in Missouri relate to capital cost increases from leasing and sub-leasing.

3. Explore methods used by states to control capital cost increases which deviate from Medicare regulations. (HCFAD is currently reviewing state plans to identify potential states.)

Visit several states, especially New York, which appears to most effectively limit capital cost increases and review equitableness of methods, cost savings, etc., and rationale for establishing methods.

4. Obtain available information (studies, etc.) from states visited to show that the methods developed were prompted by inflated selling prices and whether sales and associated inflated prices relate primarily to or between proprietary chain organizations.

5. At HCFA, Baltimore, ascertain available information on total Medicare and Medicaid costs, capital costs reimbursed, sale of medical facilities and gains, etc. Also obtain any studies, review, etc. which may indicate concern over inflated selling prices of medical facilities, related capital cost increases, and proposed methods being considered to control capital cost increases. In addition, review HCFA's progress and plans made to meet the mandate concerning establishment of a reimbursement method for the hospital capital cost component. Explore other agencies, state regulatory commissions, etc. policies on allowing capital cost increases after sale.

6. From sales reviewed, project capital cost increases to the Medicare and Medicaid programs. Devise approaches to project potential cost savings nationally to the Medicare and Medicaid programs if a method similar to that used by New York was implemented.

7. Prepare audit guides, where appropriate, to accomplish work necessary in areas previously discussed.

8. Coordinate necessary assist audits and prepare final report for submission to HCFA.

Chairman JACOBS. Mr. Rangel.

Chairman RANGEL. No questions.

Chairman JACOBS. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

What do you think we ought to do about this?

Mr. KUSSEROW. The first suggestion I might make is that we have a moratorium on permitting appreciation on the acquisitions while the Department sorts out its policy positions with regard to this issue.

Mr. GRADISON. A moratorium, a legislated moratorium while the Department develops more precise policies? Is that the essence of your suggestion?

Mr. KUSSEROW. Yes, sir.

Mr. GRADISON. Mr. Chairman, I just want to say one other thing. I thought I had studied this problem and understood it, but I was shocked, if I understand what was said a moment ago, that we are being told that a hospital which has received Hill-Burton grants for its hospital is receiving payments through the capital reimbursement mechanism of medicare for the Federal proportion of a Hill-Burton grant? Is that correct?

Mr. SIMMONS. Yes. Since the beginning of the program that has occurred.

Mr. GRADISON. I do not think anything more needs to be said about that, except it does not make a bit of sense.

Chairman RANGEL. Mr. Chairman.

Chairman JACOBS. Mr. Rangel.

Chairman RANGEL. Does State law have any effect in terms of increased Federal costs for these acquisitions, or is it only Federal regulation that governs?

Mr. KUSSEROW. As to the amount of acquisitions that are taking place, the effect on the rate of acquisition?

Chairman RANGEL. No, not the effect of the rate, but the increase in the reimbursement rate. In other words, could something like this happen in New York State?

Mr. SIMMONS. New York State I understand has a moratorium. They do not permit revaluation of assets on sale of facilities. Although we do not have firsthand information on it, I understand that there has been a containment of costs because of that provision.

Chairman RANGEL. Well, that I guess was my question, as to whether or not States could do something to curtail escalation of acquisitions.

Mr. SIMMONS. Presumably, States could follow on the coattails of New York, Illinois, and some other States.

Chairman RANGEL. Maryland?

Mr. SIMMONS. Possibly Maryland, yes, sir.

Chairman RANGEL. Thank you.

Chairman JACOBS. Mr. Pickle.

Mr. PICKLE. Mr. Chairman, I wanted to ask Mr. Kusserow. If I understood your testimony correctly, on page 3 you said that on a before and after sale basis of one hospital to another that the capital cost per patient day had increased from $32.81 before the sale to $102.32 after the sale? And in another instance you mentioned it jumped from $32 to $115.

Now, are you saying that if you had two private hospitals and one is sold to the other and the patient was charged one week $32.86 that the next week after the sale he would be charged $102.32 per patient day? The stay in the hospital would rise that much?

Mr. KUSSEROW. Yes, sir.

Mr. PICKLE. Just because of the sale?

Mr. SCHUMACHER. Yes, sir. The increased cost as a result of the sale from one cost reporting period to the next, based on the change in the operators.

Mr. SIMMONS. The increased cost, Mr. Pickle, may not necessarily be the charge to the patient. That is the cost effect. It does not necessarily translate in specific charges to the patient. If we charged based on per diem actual cost——

Mr. PICKLE. The patient does not have to pay that much. He will be paying more, but the total cost for operating the hospital went from $32 up to——

Mr. SIMMONS. That is correct.

Mr. SCHUMACHER. The bottom part of the chart shows the actual costs, actual medicare costs due to the increased capital cost. That would result in a charge to the Government. That would reflect the increased cost to the Government for medicare payments.

Mr. PICKLE. Well, now let us go a second step. If they can—whether you are right or wrong, you are making an observation that the increased cost, capital cost per hospital day, goes almost four times higher. Is it true, then, also that the hospital—if hospital A sells to hospital B, hospital A has depreciated a lot of the building and equipment down to a low level or a low basis. The new hospital buys it and he starts depreciating at the higher basis, and the cycle starts all over again.

Mr. KUSSEROW. And we have examples of where you have multiple transfers, where one chain may pick up a hospital, in turn another chain may acquire the first chain and then they might divest themselves. And each time that takes place that could occur.

Mr. PICKLE. Well, of course that is true now of real estate investments generally. People buy and sell, buy a piece of property, depreciate it down to nothing, and then they will sell it and the next guy starts doing the same thing, and that is accepted practice in the business world.

Now, are hospitals any different? Are you saying hospitals should be treated differently?

Mr. SCHUMACHER. Well——

Mr. PICKLE. I recognize they get their reimbursement. But in addition to their reimbursement, they get this higher basis. And business does not get paid back.

Mr. SCHUMACHER. One of the additional factors is that when a hospital is sold the higher cost is not just reflected in terms of additional medicare costs, in terms of additional depreciation costs, but it also allows a higher amount of interest based on the new value. And the actual—actually most of the increase in cost is not due to the higher depreciation charges, especially in these two examples. It is actually due to the increase in interest costs that can be charged to the program.

Mr. PICKLE. Now, the interest costs can be charged? It has to be reimbursed by medicare?

Mr. SCHUMACHER. On the higher value on the purchase price, and that can be passed on to the medicare program. And in many cases there is no limit on the amount that can be financed.

Mr. PICKLE. Well then, say the one hospital to another. Your contention is it gets considerable reimbursement through medicare and/or medicaid. They get a higher basis for the depreciation and they take advantage of interest deductions.

Mr. SCHUMACHER. They can in effect finance, in the case of a proprietary provider, they can finance the entire purchase price either through borrowing the money——

Mr. PICKLE. I am sure they will be testifying, but what is their answer to that procedure, the private hospitals? Are you in a position to relate to us what they tell you about why they do it?

Of course, their defense is it is a good business practice. I can see that the question is, Is it a good public policy?

Mr. KUSSEROW. Well, we do not believe that the moving force behind the increase in acquisitions is a result of medicare policy. We think there are a number of other factors which contribute to why there are acquisitions taking place. But we do know that there is certainly an incentive for acquiring—or let us say there is no disincentive for acquisitions when in fact, no matter what the purchase price is, the appreciated price is, medicare stands behind it.

So I do not think that it may be the motive force for acquisitions——

Mr. PICKLE. Are you in a position to say, if these acquisitions did not take place, the private hospital would just go out of business? Is that the alternative we face if we did not allow these mergers?

Mr. KUSSEROW. I do not believe that at all.

Mr. PICKLE. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Kusserow, I am sure you are familiar with the provision which evidently has been adopted in the Finance Committee of the other body with respect to these acquisitions. Are you familiar with it?

Mr. KUSSEROW. Yes.

Chairman JACOBS. Have you an opinion about the desirability of that, No. 1? And No. 2, does the administration to your knowledge have a position on it?

Mr. KUSSEROW. I cannot speak for the administration. That is a policy issue that is really outside my purview.

Mr. SIMMONS. On the difference of opinion about whether we would have a short-term net cost to the program because of the stopping of the recovery of depreciation, I think for that assumption to be true we have to assume that medicare drives the turnovers of facilities, and we do not believe that premise is necessarily true at all.

And I think our results and GAO's results show that there is an increased cost to the program based on acquisitions and that the moratorium would abate that increased cost.

Chairman JACOBS. I do not want you to be specific, because I do not want to give anybody any ideas. But have they overlooked anything, anyway they can milk this thing, that you know of in your expertise with these acquisitions? I mean, have they scraped the

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barrel clean? Are there some other possibilities for doing well by doing good by acquisition?

Mr. SIMMONS. As to whether, Mr. Chairman—the question, if I understand it, is whether or not there are more acquisitions that could be had out there?

Chairman JACOBS. No. I am talking about the acquisitions that have taken place. It looks to me like they have missed a trick. Can you think of any they have missed? Do not say what they are.

Mr. SIMMONS. Mr. Jacobs, if you look at chart 1, for example, the one that shows turnover of facilities, we stopped at 1983. For example, the six big chains that we demonstrated the effect of there, in 1984 those six are now five because one of those chains is now part of one of the others. So there are five remaining.

So the turnovers are continuing. They are not going to stop, we do not believe.

Chairman JACOBS. I presume there are no further questions. The committee expresses its gratitude for your contribution to the record.

Mr. KUSSEROW. Thank you, Mr. Chairman.

Chairman JACOBS. The next witness is James Isbister, senior vice president, Federal programs, Blue Cross and Blue Shield Association. Mr. Isbister.

**STATEMENT OF JAMES D. ISBISTER, SENIOR VICE PRESIDENT FOR FEDERAL PROGRAMS, BLUE CROSS AND BLUE SHIELD ASSOCIATION, ACCOMPANIED BY ALAN SPIELMAN, EXECUTIVE WASHINGTON REPRESENTATIVE, OFFICE OF GOVERNMENT RELATIONS; AND MERRITT JACOBY, EXECUTIVE DIRECTOR, MEDICARE PART A ADMINISTRATION**

Mr. ISBISTER. Thank you. Mr. Chairman and members of the subcommittee.

As indicated, I am testifying for the Blue Cross and Blue Shield Association. With me are Merritt Jacoby, who is director of our medicare part A operations, and Alan Spielman of our Washington office.

Mr. Chairman, you have posed two questions for this hearing: First, should medicare continue to permit the revaluation of assets at the time of sale? Second, are improvements needed in the implementation of the current policy, which does permit the revaluation of assets?

We have a prepared statement which I would like to submit for the record, with your permission. I can summarize it very briefly.

With respect to the basic policy question, we believe it is most timely to reconsider the medicare policy on revaluation of assets. The rules which have governed medicare reimbursement need to be evaluated against circumstances not foreseen 18 years ago when medicare began. Notably, the health care industry has new incentives to restructure itself and multifacility provider chains not so prevalent 20 years ago are now growing substantially.

In deliberating on this issue, we would suggest that you concentrate on three major questions: First, would a change in policy reduce expenditures? Second, would it alter incentives? Third, would it meet a reasonable test of reimbursement principles?

First, with respect to the question of whether a policy change would reduce the program expenditures, we believe that there would be cost savings from a moratorium on asset revaluation under medicare. However, as indicated in the testimony of others this morning, the estimates performed to date are probably overstated. Our own estimates are somewhat less.

We believe that one of the key things you might do is try to gather a more thorough analysis of the savings which could actually occur, in other words to tie this issue down.

Second, with respect to improving incentives for the medicare program or the delivery system generally, the key issue is whether changes in hospital ownership result in improvements in operating efficiency, access to care and quality of care. Mergers and acquisitions may in some instances lead to economies of scale in purchasing and administration and more efficient management, while in other cases they may have no significant effect in those areas. We believe the evidence is insufficient to reach firm conclusions on this point.

Finally, there is the question of payment to the providers. From the beginning of the program to 1983, when the DRG payment system was enacted, medicare compensated hospitals on the basis of their reasonable costs incurred in providing services to its beneficiaries. Capital costs continue to be reimbursed according to this principle.

Generally accepted accounting principles in many cases have provided a basis for the determination of what is reasonable, and it is largely on this basis that proponents of the current revaluation policy argue its appropriateness. Over the years, however, the determination of what is reasonable has been modified in many cases to reflect not only changes in accounting and tax policy, but desired changes in the incentives and the delivery system and in medicare program goals.

In summary, Mr. Chairman, we believe you face a difficult task, one of weighing the consequences of changing medicare's asset valuation policy on costs to medicare and on operating efficiencies, access to care and quality of care, and then one of determining whether you believe that program objectives and needs are such that a departure in applying cost accounting principles generally accepted by the business community is appropriate.

In our view, the evidence to support conclusions on all of these issues is uncertain. You have asked a number of us who are here today to present evidence. Perhaps then you will have ample information to decide whether the policy needs revision and when to act, now or later, if a change appears indicated.

If you decide to act now on the asset revaluation issue, we would hope that this would not divert attention from the major task of developing over the next 2 years a workable, comprehensive reform of medicare's capital payments system, a course of evaluation you clearly set in the Social Security Amendments of October 1983. We would be pleased to assist in that task as you work on it.

You have also asked whether improvements are needed in implementation of the current policy of revaluation of assets to assure that medicare reimbursement is determined correctly. The HCA/

HAI transaction was large and complex, with many potentially precedent-setting issues, some of which are not finally resolved.

Without getting into those issues or commenting on those still under resolution, we do believe that there are three lessons which should guide future actions: First, medicare reimbursement rules implementing the revaluation of assets policy need clarification in certain areas. Second, improvements are needed in the procedures governing the evaluation of appraisals. A more effective administrative effort needs to be devoted to this important function. And third, the administrative process for handling these complex transactions may need modification. Our prepared statement amplifies those concerns.

I would be pleased to respond to any questions you or members of the subcommittee may have, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF JAMES D. ISBISTER, SENIOR VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman and Members of the Subcommittee on Health and the Subcommittee on Oversight, I am James D. Isbister, Senior Vice President of the Blue Cross and Blue Shield Association, the national coordinating agency for 96 Blue Cross and Blue Shield Plans. Blue Cross and Blue Shield Plans have been heavily involved in Medicare since its beginning, and we are deeply committed to the cost effective administration of the program.

Thank you for the opportunity to comment on the issues relating to Medicare's policy of revaluing assets when a hospital or other provider is sold. The acquisition by the Hospital Corporation of America (HCA) of Hospital Affiliates International (HAI) in 1981 has focused much attention on this policy. I would note for the record that the Blue Cross and Blue Shield Association is the intermediary for the HCA home office. Blue Cross and Blue Shield of Tennessee is the Association's subcontractor for the performance of the necessary audit activity in this case. As the prime contractor for Medicare Part A administration, the Blue Cross and Blue Shield Association performed oversight of the operational issues related to this transaction.

We understand that you wish to examine two key questions in today's hearing:

1. Should Medicare continue to permit the revaluation of assets at the time of sale or merger? and;

2. Are improvements needed in the implementation of the current policy?

However, before addressing these questions, we would like to summarize briefly Medicare's current reimbursement policies relating to hospital sales and mergers.

Current Medicare Policy

Medicare reimburses capital-related costs on a reasonable cost basis. Capital-related costs include depreciation, interest, leases and rentals, return on equity capital for proprietary providers, and certain other items. Depreciation payments are based on historical costs, that is, the costs incurred by the present owner in acquiring the asset. The amount recognized by Medicare as the historical cost cannot exceed the lowest of:

1. the purchase price;

2. current reproduction cost adjusted for straight line depreciation over the life of the asset to the time of the purchase; or,

3. fair market value at the time of purchase.

A transaction permitting a revaluation of assets under these rules occurs only when the assets are purchased or a statutory merger takes place. Revaluation is not permitted in stock purchases, corporate reorganizations, and related party transactions. Interest expense incurred by the new owner to finance the purchase is allowable and any payments for return on equity capital are determined based on the newly established asset and liability values.

From the seller's perspective, the sale of the facility at a price greater than its book value triggers a depreciation adjustment. This adjustment is based on the theory that the higher sales price shows that the asset has not really depreciated in value to the

extent assumed by the useful life estimate used in calculating Medicare depreciation payments. Application of this rule results in the Medicare program "sharing" in the gain realized upon the sale. The maximum share of the gain that Medicare can receive is limited to the total amount of depreciation payments it has paid to the provider. Medicare also shares fully in any losses realized on the sale. In addition, Medicare will reimburse both buyer and seller for incurred acquisition costs, such as legal fees, accounting fees, and administrative costs of negotiating and completing the transaction. These policies apply in cases where a single hospital, profit or nonprofit, acquires another as well as to large mergers of hospital chain organizations.

Should Medicare Continue to Permit Revaluation of Assets?

It is most timely to reconsider the Medicare policy on revaluation of assets. The rules which have governed Medicare reimbursement need to be evaluated against circumstances not foreseen eighteen years ago when Medicare began. Notably, the health care industry has new incentives to restructure itself, and multi-facility provider "chains," not so prevalent twenty years ago, are now growing substantially.

In deliberating this issue, we would suggest that you concentrate on three major questions:

1) Would a change in policy reduce expenditures?;
2) Would it improve incentives?; and
3) Would it meet a reasonable test of reimbursement principles?

First, with respect to the question of whether a policy change would reduce program expenditures, we believe that there would be cost savings from a "moratorium" on asset

revaluation under Medicare. However, the estimates performed to date are probably overstated. Our own estimates, based on very limited data, suggest that the five-year Medicare savings may be less than the estimates of the Congressional Budget Office. Moreover, there are a number of complex factors that we, and perhaps the Congressional Budget Office did not take into account. We believe that a more thorough analysis of the savings estimate is warranted.

Second, with respect to improving incentives for the Medicare program or the delivery system generally, the key issue is whether changes in hospital ownership result in improvements in operating efficiency, access to care and quality of care. Mergers and acquisitions may, in some cases, lead to economies of scale in purchasing and administration and more efficient management, while in other cases may have no significant effect in these areas. We believe that the evidence is insufficient to reach a firm conclusion on this point.

Regardless of one's judgment of the value of hospital mergers and acquisitions, we doubt that a restriction in Medicare's asset revaluation policy will have significant effect on hospital acquisition and merger decisions. There are many business reasons why mergers occur, and the tax treatment of mergers is probably a much more imporant consideration in the merger decision than Medicare reimbursement considerations. Medicare payments for capital now represent only seven cents out of every Medicare dollar paid to hospitals, and the proportion of these capital payments attributable to asset revaluation will likely be relatively small.

Finally, there is the question of payment to providers. From the beginning of the program to 1983 when the DRG payment system was enacted, Medicare compensated hospitals on the basis of the "reasonable cost" incurred in providing services to its

beneficiaries. Capital costs continue to be reimbursed according to this principle. Generally accepted accounting principles, in many cases, have provided a basis for the determination of what is reasonable, and it is largely on this basis that proponents of the current revaluation policy argue its appropriateness. Over the years, however, the determination of what is reasonable has been modified, in many cases, to reflect not only changes in accounting and tax policy, but desired changes in the incentives in the delivery system and in program goals. For example, the 1972 Social Security Amendments and the Tax Equity and Fiscal Responsibility Act of 1982 set restrictions on what should be considered reasonable operating costs for Medicare. The imposition over time of these and other limits and the imposition of DRG payments in 1983 show a clear trend from the use of generally accepted accounting principles to an increasingly price-based system.

In summary, Mr. Chairman, we believe that you must weigh the consequences of changing Medicare's asset revaluation policy in three fundamental ways. First, what are the potential savings to Medicare? Second, what impact would the change have on operating efficiency, access to care and quality of care? In our view, the evidence to support answers to either of these two questions is meager or equivocal. You have asked a number of us who are here today to present evidence. Perhaps you will soon have ample information to decide whether the policy needs revision and when to act — now or later — if a change appears indicated. Third, and finally, we urge you to consider carefully whether you believe that program objectives and needs are such that a departure in applying cost accounting principles generally accepted by the business community is appropriate.

If you decide to act now on the asset revaluation issue, we would hope that this would not divert attention from the major task of developing, over the next two years, a workable, comprehensive reform of Medicare's capital payment system, a course of evaluation you clearly set in the Social Security Amendments of 1983.

We would be pleased to assist you in any way possible as you begin work on this important issue.

Are Improvements Needed in the Implementation of Current Policy?

You also have asked for comments on the implementation of the current policy on revaluation of assets. That is, are improvements needed in implementation to assure that Medicare reimbursement is determined correctly? The HCA/HAI acquisition has highlighted a number of areas where improvements are needed, and it is important to determine what lessons have been learned from that experience.

The implementation issues are very complex and it is helpful to have a basic understanding of the administrative process for handling changes in provider ownership under Medicare.

From an administrative standpoint, the first step in implementing this policy is to determine whether a sale or merger that would trigger a revaluation of assets has occurred. This step is initiated by a notice from the provider indicating that a change of ownership has or will soon occur. A legal analysis of the transaction is performed to determine whether asset revaluation is permitted. In the HCA/HAI transaction, the

With this background in mind, I would now like to clarify the current status of the HCA/HAI transaction and identify what we think are the key lessons to be learned from that experience.

Status of the HCA/HAI Reimbursement Determinations

In the course of resolving the issues related to the HCA/HAI transaction, the Blue Cross and Blue Shield Association performed the legal analysis and assisted Blue Cross and Blue Shield of Tennessee. The Tennessee Plan is the subcontractor responsible for the home office audits of HCA and HAI. While most of the issues were resolved by the intermediary, certain key issues were identified for which Medicare program policy appeared unclear. These were referred to HCFA for further analysis. It is traditional practice for intermediaries to seek the advice and counsel of HCFA on questions of reimbursement policy, particularly on those issues which are material in reimbursement effect and have a potentially precedent-setting effect. HCFA has encouraged this practice and continues to be receptive to assisting the intermediary in arriving at proper reimbursement responses. The dialogue with HCFA is continuing in order to reach a resolution of the few outstanding issues. The reimbursement determinations relating to the HCA/HAI transaction, therefore, have not been completed.

Lessons for the Future

If you decide to continue the Medicare policy on revaluation of assets, we believe there are three lessons to be learned from the HCA/HAI experience:

1. Medicare reimbursement rules implementing the revaluation of assets policy need clarification in certain areas;

Blue Cross and Blue Shield Association performed the legal analysis. As a result of this analysis, we recommended and HCFA concurred that revaluation of assets was permitted because a statutory merger had taken place.

After a determination is made that a change warranting a revaluation of assets has occurred, the issue is referred to the intermediary for the determination of the reimbursement effects. Under current treatment of acquisitions that involve one chain organization acquiring another, the intermediary for the acquiring chain's home office (administrative headquarters) takes the lead responsibility for making the reimbursement determinations. A chain organization for Medicare purposes consists of a group of two or more health care facilities that are owned, leased, or otherwise controlled by one organization. Although the home office of the chain is not a Medicare provider, the costs it incurs in managing and rendering centralized services for the chain providers are computed, allocated, and reimbursed through the individual provider Medicare cost reports.

In order to determine the proper asset basis to use for Medicare reimbursement purposes, the intermediary must have a source of information on the value of the assets. This is necessary in order to apply the limitations set forth in current policy which relate to the current reproduction costs of the assets and their fair market value. In most cases, the only source of information on asset value available to intermediaries is the appraisal. While I will address the appraisal process in further detail later in this statement, at this point I would like to emphasize that the use of appraisals, while not specifically required under current Medicare policies, is a direct consequence of these policies.

2. Improvements are needed in the procedures governing the evaluation of appraisals and more effective administrative effort needs to be devoted to this important function; and

3. The administrative process for handling these complex transactions may need modification.

Clarification of Medicare Rules

Many of the issues raised by the General Accounting Office (GAO) in its report focus on the use of Medicare reimbursement principles versus the use of generally accepted accounting principles. This distinction is critical because under Medicare rules, providers are required to use generally accepted accounting principles in claiming reimbursement in situations not covered by Medicare guidelines and policies.

We believe that the major areas where rule clarification may be needed are the handling of multiple facility acquisitions, the recognition and allocation of new and assumed debt, favorable financing and favorable lease terms, and the conduct and content of appraisals. These areas also are identified in the GAO report. HCFA and the intermediaries are working together to research and resolve these issues. Of these areas, the handling of appraisals probably presents the most difficulties and the solution will require more than simply clarifying the rules.

Handling of Appraisals

The intermediary is responsible for deciding whether an appraisal associated with a revaluation of assets should be accepted or rejected for Medicare reimbursement purposes.

Appraising the many different types of assets that are part of a health care institution, and then of a number of institutions in many different locations, is a complex task and one that calls for particular expertise and experience. There are, for example, a wide variety of asset categories, including buildings, real estate, and medical and business equipment. The assets in these categories are of various levels of quality and age which further complicates the task. The appraisal of intangible assets, such as lease rights, also may be involved.

A comprehensive evaluation of the reasonableness of these complex appraisals requires a reviewer with a high level of expertise and experience in appraisals. Intermediaries do not have that expertise. Therefore, the intermediary review of the appraisal now focuses on procedural — not substantive — aspects of the appraisal including:

- Whether or not the organization used was recognized as a qualified appraiser;
- Whether or not the appraisal provided the information required under Medicare guidelines; and
- Whether or not the appraiser was responsive to questions and additional information needs.

In retrospect, we have learned that this level of evaluation may not be adequate to identify all irregularities in the appraisal that may have a significant effect on Medicare reimbursement. Addressing this problem for the future will require a comprehensive approach involving improvements in certain Medicare guidelines and administrative improvements at the intermediary level. The specific areas that are being explored are:

1. Qualifications of the appraisal firm. Under current rules any appraisal must be conducted by a recognized and approved appraisal firm knowledgeable in Medicare requirements. We have not been able to identify any formal certification process for appraisers. Generally, the firms become recognized by the fact that they have been used by health care providers.

2. Independence of the appraisal firm. The appraisal firm should be independent. However, in most cases, the firm is chosen by and paid by the provider. We need to explore the possibility of having the intermediary hire independent appraisers in certain cases for a "second opinion.".

3. Content and Conduct of the Appraisal. Medicare guidelines may need revision to define more specifically what elements should be included in the appraisal. Also, it may be necessary to restrict the methods that appraisers can use in determining fair market value for Medicare reimbursement purposes.

4. Access to Appraisal Expertise. Additional efforts directed toward the review of the qualifications of the appraiser and the content and conduct of the appraisal may prove adequate to prevent abuse. If, however, they are not,

the Medicare program could take a more active role in dealing with the results of the appraisal. This will require access to appraisal expertise. All intermediaries or a designated few could begin building their own in-house appraisal capacity. In our view this approach would not, however, be cost-effective given the relatively low volume of these transactions. Other alternatives include:

- o development of appraisal expertise at HCFA or another government agency;

- o development of a Medicare-approved list of qualified independent appraisers whom intermediaries could turn to for a "second opinion."

Improvements in the evaluation of the appraisal will not solve all of the problems associated with the handling of complex multi-facility acquisitions or mergers. A comprehensive approach to these problems also requires consideration of changes to the process for handling these transactions at the intermediary level.

The Administrative Process

HCFA and the intermediaries have been exploring ways to improve the coordination of effort in the analysis of these transactions. While this effort is ongoing, some general directions have emerged:

- o Reimbursement expertise in specialized areas such as chain organizations and hospital acquisitions may need to be focused at fewer sites;

- Legal expertise may need to be strengthened; and

- Coordination between HCFA certification decisions and intermediary reimbursement determinations needs improvement.

We are also strengthening our capacity within the Blue Cross and Blue Shield Association to assist Plans in dealing with the complexities associated with reimbursement for chain organizations and to review centrally all audits of chain home office costs. Additionally, on a case-by-case basis, we are moving towards concentrating the responsibility for all providers in a chain with the subcontracting Blue Cross Plan that handles the chain's home office operations.

Conclusion

To summarize, we believe that the evidence on the basic policy question of whether Medicare should continue to permit revaluation of assets is inconclusive. We hope that any efforts on this specific issue do not divert attention from the major task of reforming all of Medicare's capital reimbursement policies. If you decide to continue the current policy, we believe that its implementation should be improved through clarifying certain rules, improving the process for the evaluation of appraisals, and exploring alternative administrative approaches to the handling of these complex transactions. Finally, we would note that the revaluation of assets policy applies not only to acute care hospitals but to all Medicare providers that are paid on a cost basis. We would urge you to consider the issues relating to these providers as you explore whether changes should be made.

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Chairman JACOBS. Thank you very much, Mr. Isbister.

Mr. Rangel.

Chairman RANGEL. Tell me. The previous witness showed a dramatic increase in patient cost as a result of the medicare reimbursement formula, I thought. So clear up for me where you point out in your testimony that medicare reimbursement is but a small factor in the increase in costs.

Mr. ISBISTER. The point made there, Mr. Chairman, was in the context of whether a shift in medicare policy would itself have a pronounced effect on incentives for acquisition transactions. As other witnesses have indicated, we believe that medicare policy changes by themselves are not likely to have a great effect, either retarding or enhancing the acquisition.

Chairman RANGEL. Well, assuming you are not opposing the acquisitions, but you are concerned with the increase in reimbursements, then I ask the question, if we change the medicare reimbursement rules so that you could not use accounting formulas to increase the Government's responsibility for reimbursing capital costs following an acquisition, then would you find the same increase in cost per patient?

Mr. ISBISTER. It would vary with the circumstances of an individual case. In the aggregate, as I have indicated in my testimony, we believe that if you were to change the policy you would realize savings in medicare reimbursements in the aggregate. But the savings will vary case by case.

What you saw this morning is probably one of the most dramatic, worst-case examples, if you will.

Chairman RANGEL. OK. But repeat your testimony that dealt with the 7-percent figure as it relates to medicare reimbursement.

Mr. ISBISTER. Referring in my formal statement to—let me see if I can find it.

Chairman RANGEL. Maybe Mr. Gradison can help me out, because I thought he and I were under the impression that a lot of the dramatic increase in per patient costs and Federal reimbursement was due to existing medicare rules. And I think I heard you say that in terms of factors that cause acquisitions the medicare regulation is almost insignificant and that it would not impede acquisitions. I have not heard anyone being against acquisitions. We are concerned with increased costs.

Mr. ISBISTER. Payments for capital are 7 percent of total medicare expenditures. The point I was trying to make, Mr. Chairman, was one that two other witnesses this morning have made—and it was really an aside.

It is our opinion that a change in medicare policy is not likely to have a substantial effect either in retarding the rate of acquisitions that occur in the private sector or promoting acquisitions, because those decisions will be made on the basis of other business considerations. That is my point.

Chairman RANGEL. I understand that, but I do not know why you make that point. I mean, it is not as though this hearing is to stop people from merging or having acquisitions. If they believe that this is sound health delivery policy or that it will improve their ability to do business, that is good.

But what we are here for is to ask you experts, are these acquisitions causing an increase in Federal expenditure because of medicare formulas?

Mr. ISBISTER. As I have testified, we believe that precise evidence on that is not available.

Chairman RANGEL. What about all these charges?

Mr. ISBISTER. We believe in the aggregate that it does increase the expenditures to medicare.

Chairman RANGEL. Well, help me out. You saw all those charts that were there, and how dramatically medicare capital costs increased after acquisitions. Would you respond to those charts?

Mr. ISBISTER. Those particular cases, Mr. Chairman, I am not familiar with. They were derived from the analysis of some specific cases that the Inspector General went over.

Chairman RANGEL. That is OK. Do you have any understanding of the General Accounting Office report at all?

Mr. ISBISTER. Yes, sir.

Chairman RANGEL. Are they basically correct?

Mr. ISBISTER. We believe that they are correct with respect to the impact of the revaluation of assets policy on medicare expenditures; namely, that it does increase medicare expenditures. But what is uncertain is the answer to the argument that says that there are compensating advantages obtained from acquisitions, which say that as a result of improved management, greater efficiency of operation, there is an offset that needs to be taken into consideration.

That is a long-term effect. Everybody is groping to see what those consequences are.

Chairman RANGEL. Why do we have to do that? If I understand your testimony, when hospital professional people decide to merge or have acquisitions, the medicare reimbursement is a small factor that is before them when they make the decision; that most of the decisions are based on sound management principles, and to improve the quality of health care that they can deliver.

Now, if that is so, changing the medicare formula so that the Federal Government's costs do not go up following an acquisition would not at all stop the acquisitions, or at least 93 percent of them. So we do not have to consider the offsetting advantages at all.

Mr. ISBISTER. We are in agreement on that point, Mr. Chairman.

Chairman RANGEL. Good. Thank you.

Chairman JACOBS. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

It is my understanding that under present law in a case like this, where the General Accounting Office has prepared a report, the Department which is affected, which is HHS in this instance, is required to report within 60 days to the Congress with its specific comments.

I wrote a letter to the Secretary of Health and Human Services on January 18 transmitting a copy of this report and calling attention to this requirement. And more than 60 days has gone by and I just want to say for the record that I hope that the testimony before us today is not considered by the Department to be a response to the General Accounting Office report, because it is not.

And I would like to know when we are going to get a response which gets into the specific points raised in that report.

Mr. ISBISTER. Mr. Chairman, the unresolved issues in that report, as I indicated, have been under discussion between ourselves as the fiscal intermediary and the Department over a period of time. Ms. Feinstein, who will be here, I think, will be testifying to the Department's action on that report.

Mr. GRADISON. You mentioned a 7-percent figure. I have heard it used often as a measurement of the percentage of costs of hospital operations that is accounted by capital—capital is 7 percent of total costs, 93 percent would be operations. What part of that 7 percent would you say is a result of this revaluation factor? I am trying to carry Mr. Rangel's question a little bit further.

Mr. SPIELMAN. We do not have information to make that estimate. In looking at this question, we made an assumption that it may be 20 percent, but there is no hard evidence to come up with that.

The point we were trying to make is that with capital costs representing 7 cents on the dollar, 20 percent of that is a rather small portion of the total medicare dollar that is being paid to hospitals.

Mr. GRADISON. We are being asked in certain alternatives to add, let us say, 7 percent to the present DRG's as a method of incorporating capital reimbursement in the DRG system. The question, therefore, is whether the 7 percent is inflated. It may well be that 7 percent overstates what we should add.

As I understand, you have got studies under way with regard to capital; is that correct?

Mr. ISBISTER. That is correct, sir.

Mr. GRADISON. I hope that these studies will therefore permit us—I hope you give us enough detail that we can go back and examine whether that 7 percent is correct.

In other words, if you look at all hospital costs and 7 percent of all hospital costs are capital, that does not answer the question. I think we have to see how those costs are computed.

Mr. ISBISTER. Yes, sir.

Mr. GRADISON. How about this matter of recapture of depreciation? It was supposed to be recaptured. Do you have any figures as to how much has been recaptured under medicare?

Mr. ISBISTER. No, I do not. As Mr. Kusserow indicated, that is an inquiry which is being undertaken by the Department of HHS. I do not have any estimates as to that.

Mr. GRADISON. When might we expect to have that? Do you have any guess?

Mr. ISBISTER. You would have to ask the witness from the Department.

Mr. GRADISON. We will wait for that, then. Thank you.

Chairman JACOBS. Mr. Pickle.

Mr. PICKLE. I have no questions.

Chairman JACOBS. In that case, we thank you, gentlemen.

Mr. ISBISTER. Thank you very much, Mr. Chairman.

Chairman JACOBS. Mr. Samuel Howard, vice president and treasurer, Hospital Corporation of America.

Mr. Howard, you are welcome to submit your statement for the record and hit the high points, although I am not sure your corporation has not already done that, but go on.

**STATEMENT OF SAMUEL H. HOWARD, VICE PRESIDENT AND TREASURER, HOSPITAL CORPORATION OF AMERICA, ACCOMPANIED BY JAMES SMITH, DIRECTOR OF GOVERNMENT RELATIONS**

Mr. HOWARD. Thank you, Mr. Chairman.

I am Samuel Howard. I am vice president and treasurer of Hospital Corporation of America. Accompanying me today is James Smith, director of Government relations. My remarks today will focus on medicare's current policies regarding valuation of assets and the recent General Accounting Office report on this subject.

Before I do so, I would like to emphasize two important facts about acquisitions and medicare policy. First, revaluation of assets is not a significant factor in encouraging hospital mergers and acquisitions; and, second, medicare revaluation of assets affects both tax-exempt and tax-paying hospital systems.

Hospital consolidation of tax-paying and tax-exempt institutions continues to be an inevitable reaction to increasing complexities in our health care delivery system, greater regulatory burdens associated with the cost containment imperatives strongly supported by this committee, and attempts to improve access to capital in an increasingly competitive and uncertain environment.

With this preamble I will now focus on the issue before the committee.

In December 1983 the General Accounting Office issued its report on the impact on medicare of hospital mergers and acquisitions and used the HCA/Hospital Affiliates International merger as a case study. It focused almost exclusively on accounting issues and not on the basis for, nor the implications of, medicare policy. It did not consider the fundamental economic reasons for capital cost increases which result from hospital mergers, nor the explicit recognition of the current medicare policy of this underlying economic rationale.

Our detailed comments concerning the GAO report are included in appendix VI of that report, and we continue to stand by these comments and take exception to the GAO's interpretation of the complex medicare guidelines which apply to the merger.

The medicare fiscal intermediary extensively audited the merger and has given its preliminary approval. We are confident that HCA has carefully complied with current medicare policies and believe that our interpretation will be ultimately concurred in by the Federal Government.

With respect to the broader issue, the medicare program has known for years that its payment of depreciation does not adequately reimburse hospitals for the cost of capital assets. How then can medicare depreciation policies based on original asset cost begin to provide hospitals with adequate financial resources to replace assets which are consumed in part by medicare patients? Such a policy regarding payment for replacement of assets is only relevant if there is little or no inflation.

Accountants compute depreciation expense based on the current owner's actual cost of purchase or actual cost of construction. While this does not adequately recognize the effects of inflation, and thus does not provide for the recognition for the cost of replacing an asset, it is the only system available.

The way the accounting profession attempts to reflect its inability to depreciate assets at current replacement value is to revalue assets at the time of sale. Because the purchaser's cost more closely approximates the replacement cost of the assets, depreciation on this basis provides the buyer a better book approximation of the value of the assets used up in the conduct of the business. Even this method is inadequate since in the years following a purchase, depreciation is again based on costs in the year of acquisition, and as a result of inflation, will again understate replacement costs.

In recognition of this understatement, the SEC and the Financial Accounting Standards Board require public corporations such as HCA to report the current replacement costs of fixed assets. Similarly, public corporations use current replacement costs as the basis for insuring assets. Also, the IRS computes income taxes at the time of sale based on current values measured by the actual price paid. Thus, original historical cost is largely irrelevant when valuing fixed assets in our private economic system.

Medicare cost reimbursement principles essentially follow generally accepted accounting principles in that depreciation and interest payments are based on historical costs, but not original historical costs.

Although medicare follows generally accepted accounting principles, it has strict reimbursement guidelines relative to revaluation of assets, denial of reimbursement for goodwill, depreciation recapture and requirement for bona fide arms-length transactions.

It has been suggested that medicare cost reimbursement should follow New York State's example and reflect only historial cost to the original owner. Such a change in policy, in my opinion, would be ignoring economic reality. The original construction cost of a hospital is no more relevant to replacement cost or actual value than the original cost of a house 30 years ago.

In our opinion, a limitation to original construction costs would mean that the medicare program would not be paying true inpatient capital costs associated with delivering patient care to its beneficiaries.

It has been further suggested that the medicare program pays twice for the same facility by having previously paid depreciation to the seller and paying it again to the buyer. This, too, is a misconception. Medicare does not pay twice for the same facility as they did in New York State in the 1970's, because it recaptures previously paid depreciation and further reduces the buyer's depreciable appraisal value by the amount of depreciation associated with the prior consumed life of the assets.

Finally, this committee should also consider that a limitation to original cost would be inconsistent with the medicare policy on donated assets. Further, the Federal Government's policy to require revaluation of assets and recovery of grant funds for Hill-Burton-financed hospitals would be in conflict with any new medicare policy to limit asset values to the original construction cost.

In summary, asset revaluation is an essential principle of our economic system, and until such time as an alternative medicare capital payment method is developed, it should be retained in the medicare program.

Proponents of a change in medicare policy have argued that current policy encourages mergers and that these mergers in turn have adverse cost implications for the Federal Government. We believe that a careful review of the facts will leave the committee to reject both propositions.

Most readers of the GAO report have focused almost exclusively on GAO's estimate that HCA's annual capital costs as a result of the merger increased by approximately $55 million. They have erroneously assumed that the medicare program is bearing a substantial portion of that increase. Because current medicare policy does not allow payment for goodwill and medical office buildings, included in this $55 million figure, the annual cost to the medicare program of the merger was approximately $8 million.

GAO, on the other hand, considered as irrelevant the importance of substantial tax gains to Federal and State treasuries arising out of the merger; $135 million in Federal capital gains tax liabilities were incurred, of which approximately $85 million in taxes was actually paid in 1982. From a total Federal Government perspective, these Federal taxes offset the increased costs to the medicare program. Also, States in which HAI hospitals were located similarly received $25 million in capital gains taxes. We believe that the committee will agree that the Federal and State governments clearly gained by the HCA merger.

Of equal concern to HCA is our belief that all of our patients benefited from the merger. As GAO recognizes, consolidation of operations does produce economies of scale and cost savings, but with the exception of reduced home office costs, these savings were realized over time, and they are difficult to isolate after the consolidation takes place.

HCA is confident that as a result of these efficiencies and the company's ability to commit the human and capital resources which the former HAI hospitals required, patients as a whole benefited from the merger. HCA did not increase patient charges at any of the acquired hospitals at the time of the merger. Additionally, increases at these facilities for the following year were less than the national average increase for hospital care.

Proponents of eliminating revaluation have argued that revaluation of assets encourages merger and acquisition activity, in some cases simply for the reimbursement gain involved. We are not aware of any evidence to support this allegation, and we suggest that the following factors argue convincingly against any medicare role.

First, as described earlier, medicare's basis for determining depreciation is highly restrictive, including depreciation recapture and limiting the amount of depreciable value the buyer can claim reimbursement for.

Second, presently, medicare pays approximately 80 percent of charges.

And finally, the ability to shift any resulting cost shortfalls from medicare and medicaid to private patients is becoming increasingly

difficult as employers and private insurers pursue their appropriate cost-containment strategies.

As a result, revaluation of assets, while it may be meaningful in keeping cost shifting within tolerable levels after a hospital merger occurs, clearly does not act as any incentive to such consolidation. Hospitals must provide medicare and medicaid services if they are to meet their public missions. But to suggest that a high medicare patient load is an inducement to acquisition is simply not recognizing economic reality. An $8 million medicare payment is an insignificant factor in making a corporate decision to invest about a billion dollars.

It is true that prices for hospital facilities are often higher than reproduction costs, but our experience clearly suggests that this is a direct result of Federal and State regulations of capital in the form of a certificate of need and the section 1122 programs. These programs imbue existing hospitals with a premium which is often reflected in the price of hospitals but which is not recognized by current medicare cost-reimbursement policies.

Thus, disallowing a revaluation of assets would in the final analysis merely increase the drag of the medicare caseload as a factor in a particular acquisition. In that sense, hospitals with high medicare and medicaid patient loads would probably suffer somewhat in their acquisition value, should a change in policy occur.

The overall impetus toward consolidation, which I stated in my opening remarks, will not in my opinion be altered.

In conclusion, it is our opinion that medicare policy which recognized revaluation of assets at the time of purchase is:

One, consistent with fundamental and longstanding accounting principles and economic reality.

Two, consistent with a policy to replenish capital for the replacement of assets.

Three, an essential element of capital cost-based reimbursement.

Four, cost neutral if not cost beneficial to the Federal and State governments with respect to taxpaying hospitals' acquisitions.

And, five, not an inducement to hospital acquisitions and resale.

As long as medicare continues to use a cost basis for hospitals' capital reimbursement, it should continue to recognize actual costs and not original historical costs which bear no relationship to the costs of the current provider.

The Congress has commissioned the Secretary of Health and Human Resources to conduct a study of capital-related costs and report in October of 1984, 7 months away. While we do not know what the outcome of this study will be, it appears somewhat imprudent and unwise to commence to making changes in such a complex issue on a piecemeal basis.

In conclusion, the committee must recognize that hospitals, tax-exempt and taxpaying, will continue to consolidate and merge to solve their business problems. It is essential that medicare pay its fair share of a hospital's actual capital costs, including costs incurred as a result of acquisitions. As this committee considers how to integrate capital considerations into medicare's prospective payment system, it must assure that adequate capital is available to preserve our quality health care delivery system.

Thank you for the opportunity to present our views. I will be happy to answer any questions.

[The prepared statement follows:]

STATEMENT OF SAMUEL H. HOWARD, VICE PRESIDENT AND TREASURER, HOSPITAL CORPORATION OF AMERICA

Thank you, Mr. Chairman.

My name is Samuel H. Howard. I am Vice President and Treasurer of Hospital Corporation of America in Nashville, Tennessee. My remarks today will focus on Medicare's current policies regarding valuation of assets and the recent GAO report on this subject.

Before I do so, however, I would like to correct two important misconceptions that surround the issue before the Committee today. Medicare policy, with regards to revaluation of assets, is a significant factor in hospital mergers and acquisitions; and this same policy is somehow only applicable to tax-paying hospital systems like HCA.

HCA's growth from one hospital just fifteen years ago to today's system of hospitals of every size, type and circumstance, including 170 voluntary tax-exempt, municipal, or county-owned hospitals, is a graphic representation of the consolidation of this nation's hospital sector. This consolidation has occurred at a rapid pace and is embracing every aspect of the hospital sector, taking a variety of organizational forms, both tax-paying and tax-exempt. Although much has been made of the growth of tax-paying hospital systems like HCA, the relative number of tax-paying hospital beds has remained constant at 11.6% of total

hospital beds over the last five years, based on the most recent data available. Tax-exempt multi-hospital arrangements, in fact, account for about two-thirds of the hospital beds in the U.S.

I can think of no greater change in the hospital sector than this consolidation: In 1982, one of every three acute care community hospitals in this country was a member of some type of hospital system. The reasons for this consolidation are several and well known by the members of this Committee:

- Hospitals have become increasingly complex and specialized as medicine has become more and more sophisticated; therefore, the demand for management systems has increased.

- A vastly greater regulatory burden tied to both third party payment and capital control requires an administrative overhead that many hospitals cannot individually support.

- Greater competition coupled with major renovation and replacement needs require hospitals to join together to attempt to secure access to capital in an increasingly uncertain environment. Capital starvation is one of the single most important problems facing hospitals today.

These factors continue and, in fact, are intensifying as a result of the fundamental changes in hospital payment which the 98th Congress legislated into law last year, placing a premium on the effective management of cost.

In essence, hospital consolidation of tax-paying and tax-exempt institutions continues to be an inevitable reaction to advances in health care and the cost containment imperatives strongly supported by this Committee.

With that as context, I would now like to turn to the issue before the Committee today.

## GAO REPORT

In December of 1983, the General Accounting Office completed its review of the impact on Medicare of hospital mergers and acquisitions. GAO's report, using the HCA/HAI merger as a case study, focused almost exclusively, however, on the manner in which the merger was accounted for and not on the basis for and implications of Medicare policy. In particular, GAO did not address the impact of Medicare policies concerning the revaluation of assets for tax-exempt and tax-paying hospitals. Our detailed comments with respect to the GAO's findings are included as Appendix VI of the report. We continue to stand by those comments and to take exception to GAO's interpretation of the com-

plex guidelines which govern Medicare's accounting for HCA's 1981 merger with Hospital Affiliates International. As noted in our comments, Medicare's fiscal intermediary extensively audited this transaction and has given its preliminary approval. We are confident that HCA has carefully complied with Medicare policies as they currently exist and believe that our interpretations will be ultimately concurred in by the federal government.

With respect to the broader public policy concerns which this Committee is focusing on, the report, aside from a cursory description of cost-based reimbursement principles, neither addresses the fundamental economic reasons for capital cost increases which result from hospital mergers nor the explicit recognition in Medicare policy of this underlying economic rationale.

## ACCOUNTING PRINCIPLES FOR ASSET REVALUATION

The Medicare program has known for years that its payment of depreciation does not adequately reimburse hospitals for the cost of capital assets. How can Medicare depreciation policies based on original asset cost begin to allow hospitals to replace assets which are consumed in part by Medicare patients? Such a policy regarding payment for replacement of assets is only relevant if there is little or no inflation. It is no surprise then that capital cost increases in hospitals, as in every other sector of our economy, are directly a result of increases in construction costs and interest rates. During the period 1970-1980, the construction cost index alone rose by almost 130%. Double-digit interest rates over the past four years have further inflated capital costs.

Accountants compute depreciation expense based on the current owner's actual cost of purchase or actual cost of construction. While this does not adequately recognize the effects of inflation, and does not provide for the recognition of the cost of replacing an asset, it is the only system available. A change in generally accepted accounting practices has not occurred because of a lack of agreement on the technical mechanism, not because of any fundamental disagreement on the need for such corrections.

The only way the accounting profession corrects the inability to depreciate assets at current replacement value is to revalue assets at the time of sale. Because the purchaser's cost more closely approximates the replacement cost of the assets, depreciation on this basis allows the buyer to replace the assets used up in the conduct of its business. Even this method is inadequate since in the years following a purchase, depreciation is again based on costs in the year of acquisition, and as a result of inflation, may seriously understate replacement costs.

In recognition of this understatement, the Securities and Exchange Commission and the Financial Accounting Standards Board require public corporations such as HCA to report annually to the public the current replacement costs of all their fixed assets, constructed as well as acquired. Similarly, public corporations use current replacement costs as the basis for insuring assets. Moreover, the IRS computes income taxes at the time of sale based on current values measured by the actual price paid. Original historical cost is largely irrelevant when valuing fixed assets in our economic system.

Given the inadequacy of the traditional depreciation mechanism during an inflationary period, a responsible tax-paying or tax-exempt hospital, indeed any entity, must include as an element in its price an amount sufficient to assure asset replacement in the future. Medicare, as a cost-based system recognizing only depreciation, has denied hospitals the ability to act in such a responsible manner and has encouraged instead the use of debt financing to make up the shortfall.

## MEDICARE POLICY

Medicare cost reimbursement principles essentially follow the universally accepted accounting principles described above in basing depreciation and interest payments on historical costs. Similarly, in the absence of any mechanism to continually update asset values to reflect their replacement costs, only when a hospital is purchased, are asset values appropriately updated. If revaluation occurs after a period of staggering inflation, such as between 1970-80, then the magnitude of the revaluation can be significant.

Although Medicare follows Generally Accepted Accounting Principles, it additionally carefully circumscribes revaluation of assets in the following manner:

First, Medicare rules strictly limit the circumstances in which revaluation of assets can occur to those instances where assets are purchased and specifically does not allow revaluation where the shares of a hospital corporation, without regard to its tax status, are purchased. The result is that only a portion of hospital "acquisitions" is recognized for the purposes of asset revaluation.

Second, the Medicare rules restrict the extent to which increased costs are recognized, by basing depreciation on the lower of either:

(a) cost of the asset to the purchaser;

(b) current reproduction cost adjusted for straight-line depreciation over the life of the asset up to the time of purchase; or

(c) fair market value.

Third, purchased goodwill and that portion of the interest cost related to goodwill are specifically excluded by Medicare.

Fourth, depreciation paid previously by Medicare is recaptured.

Fifth, only bona-fide arms-length transactions are recognized.

Notwithstanding the cost implications (which are discussed below and shown to be significantly exaggerated), asset revaluation remains an essential principle of cost-based reimbursement, and until such time as an alternative capital payment method is developed, should be retained.

Ignoring the clear economic rationale, in favor of short-term budget imperatives, has led some to suggest that cost reimbursement should reflect only historical cost to the original owner. The original construction cost of a hospital is likely to be no more relevant, however, to the current hospital management's cost than the original cost of building a house thirty years ago is to the current owner's costs. Original cost reimbursement in the hospital sector would be no less inappropriate than rent controls in the housing sector and would effect the same inevitable result of a deterioration in quality and capacity.

This deterioration is evident in New York State, which in response to serious problems in the nursing home industry, took the drastic step to limit reimbursement beginning in 1976 to original construction cost. As a result of this and other restrictive policies, the physical plants of New York City hospitals in comparison with the nation's hospital stock as a whole are substantially deteriorated and are in critical need of replacement. Furthermore, NYU, under a grant from The Commonwealth Fund, has documented that New York City's hospitals are carrying almost twice the long-term debt and only half the reserves of the nation's average. We believe that this deplorable situation is substantially a function of the economic imperatives of a cost-based system, which I described earlier.

It should be noted that New York's policy was not as restrictive as Medicare's when the nursing home abuses occurred in that state in the 1970's. By not recapturing previously paid depreciation, New York may have found itself paying for the same facility twice. Had the Medicare restrictions been in place, the experience in New York may have been substantially different.

Medicare, by contrast, does not pay twice for the same facility by recapturing previously paid depreciation and by reducing the buyer's appraised value by straight-line depreciation.

Finally, this Committee should bear in mind that an emphasis on original cost would cast considerable question on policies in other areas, such as the policies on contributed assets and on hospitals built with Hill-Burton grants. The granting of depreciation for contributed assets in which there is no historical cost is a Medicare policy critical to hospitals relying on significant philanthropic contributions, and has enabled hospitals to value the contributed assets at their appraised fair market value. Also, the federal government's policy to require revaluation of assets and recovery of grant funds on hospital acquisitions where the hospital was built with Hill-Burton grants will become inconsistent with a Medicare policy to limit asset values to original construction cost.

## IMPLICATIONS OF MEDICARE POLICY

Proponents of a change in Medicare policy have argued that current policy encourages mergers and that these mergers in turn have adverse cost implications for the federal government. We believe that a careful review of the facts will lead the Committee to reject both propositions.

### Cost Implications

The Medicare limitations described above have important cost implications for the federal government which are obscured in the GAO report but are critical to this Committee's assessment of current policy.

The press and casual readers of the GAO's report have focused almost exclusively on GAO's estimate that HCA's annual capital costs as a result of the merger increased by approximately $55 million and have erroneously assumed that Medicare is bearing some substantial portion of that increase. The fact of the matter is that Medicare's payment under the current cost-based reimbursement method increased by approximately $8 million (see Attachment A). Thus, although Medicare utilization accounts for approximately 35% of hospital days in the HAI hospitals, Medicare is bearing only about 15% of HCA's capital cost increase. Rather than concluding that Medicare's payment in this regard was excessive, this Committee might well question whether the program is paying its fair share.

GAO has also inexplicably minimized the importance of substantial tax gains to federal and state treasuries arising out of the merger. The fact is that $135 million in federal capital gains tax liabilities were incurred, of which approximately $85 million in taxes were paid in 1982, offsetting the increased costs to the Medicare program. Similarly, states in which HAI hospitals were located received $25 million in capital gains taxes, again more than offsetting any incremental cost increases to publicly financed programs in those states. While it is true

that the Medicare trust fund and general treasury revenues are separate and distinct, this Committee's purview over both taxes and the entitlement programs requires that it consider implications for both areas.

On balance, we believe that the Committee will agree that the federal and state governments clearly gained by the HCA merger.

Of equal concern to HCA, however, is our belief that all of our patients benefited from the merger. Our answer is unequivocally "yes". Again, casual readers of the GAO report have ignored GAO's own findings in assuming that HCA's increased capital costs were not offset by savings arising from the merger and instead borne by patients in the acquired facilities. As GAO recognizes, consolidation of operations does produce economies of scale and cost savings, but with the exception of reduced home office costs, these savings are realized over time and are difficult to isolate after the consolidation takes place. HCA is confident that as a result of these efficiencies and the Company's ability to commit the capital and human resources which the former HAI hospitals require, patients as a whole benefited from the merger. Notwithstanding the methodological difficulties of isolating and tracking savings which accrued from the merger, GAO's own examples bear out the fact that at the time of the merger, acquired hospitals did not experience concurrent charge increases; and subsequent charge increases in the year following the merger were less than the national average.

Encouragement of Merger Activity

Proponents of eliminating revaluation have argued that revaluation of assets encourages merger and acquisition activity, in some cases simply for the reimbursement gain involved. I am not aware of any evidence to support this allegation of "trafficking" in the hospital sector, and I suggest that the following factors argue convincingly against any Medicare role:

First, as described above, Medicare's basis for determining depreciation is highly restrictive, including recognizing at a maximum current reproduction costs less straight-line depreciation. As described earlier, as a result of these restrictions, Medicare bore about 15% of HCA's capital cost increases, while Medicare patients represent approximately 35% of the patient load.

Second, presently, Medicare pays only approximately 80% of a hospital's charges; and although under the new DRG payment method, some hospitals will be able to keep a portion of their savings if they manage their costs more efficiently

than the average, as the overall system becomes more efficient, this net margin will become narrower for even the most efficient hospital.

Finally, the ability to shift the resulting cost-shortfalls for Medicare, and the additional shortfalls from Medicaid and indigent patients, to private patients is becoming increasingly difficult as employers and private insurers pursue their own cost containment strategies.

As a result, revaluation of assets, while it may be meaningful in keeping cost shifting within tolerable levels after a hospital merger occurs, clearly does not act as any incentive to such consolidation. Hospitals must provide Medicare and Medicaid services if they are to meet their public missions. But to suggest that a high Medicare patient load is an inducement to acquisition is simply not realistic.

It is true that prices for hospital facilities are often bid up well above reproduction costs, but our experience clearly suggests that this is a direct (albeit a perverse) result of federal and state regulation of capital in the form of certificate of need and 1122 programs. These programs imbue existing hospitals with a premium which is often reflected in the price of hospitals but which is not recognized by Medicare cost reimbursement policies.

Thus, disallowing a revaluation of assets would in the final analysis merely increase the "drag" of the Medicare case load as a factor in a particular acquisition. In that sense, hospitals with high Medicare and Medicaid patient loads would probably suffer somewhat in their acquisition value should a change in policy occur.

The overall impetus toward consolidation, which I preceded my remarks with, will not in our opinion be affected.

## CONCLUSION

In conclusion, it is our opinion that Medicare policy which recognizes revaluation of assets at the time of purchase is:

- Consistent with fundamental and longstanding accounting principles and economic reality.
- Consistent with a policy to replenish capital for the replacement of assets.
- An essential element of cost-based reimbursement.

- Cost neutral if not cost beneficial to the federal and state governments with respect to tax-paying hospitals' acquisitions.

- Not an inducement to hospital acquisition and resale.

As long as Medicare continues to use a cost basis for hospital capital reimbursement, it should continue to recognize actual costs and not a historic cost artifact which bears no relationship to costs of the current provider. If the Committee determines that there is lack of clarity of Medicare policies, then until a prospectively determined capital allowance is developed, these policies should be clarified to meet the specific concerns of the Committee.

The Committee must realize that hospitals, tax-exempt and tax-paying, will continue to consolidate and merge to solve their problems. In retrospect, it is clear that the cost-based reimbursement system has not only led to inefficiency on the operating side, but having been applied during a period of inflation, has resulted in significant decapitalization and an unhealthy reliance on debt financing. The only time hospitals' true capital costs are recognized for financial and Medicare payment purposes is at the time the acquisition occurs. It is essential that Medicare pay its fair share of a hospital's actual capital costs, including capital costs incurred on acquisitions. Otherwise there will be an increase in cost shifting. As this Committee considers how to integrate capital considerations into Medicare's new prospective payment system, it must assure that adequate capital be available to preserve our quality health care delivery system.

ATTACHMENT A

ESTIMATED MEDICARE REIMBURSEMENT
RELATED TO THE HAI MERGER

| GAO REPORT REFERENCE | DESCRIPTION | AMOUNT (MILLION) |
|---|---|---|
| III | TOTAL CAPITAL COST INCREASE | $55.2 |
| | LESS: | |
| 19,23,71,73 | INTEREST COST ON GOODWILL DEBT | 29.5 |
| 10,11,20,60 | DEPRECIATION AND INTEREST COST ON MEDICAL OFFICE BUILDINGS | 2.6 |
| | TOTAL ALLOWABLE COST | $23.1 |
| | MEDICARE UTILIZATION | 35% |
| | MEDICARE REIMBURSEMENT | $8.1 |

Chairman JACOBS. Mr. Rangel.

Chairman RANGEL. Thank you, Mr. Howard. Let us see how much of an area of agreement we have, and then I could ask you some questions.

About the fact that revaluation is a fundamental, longstanding accounting principle, there is no argument. We created it. So we are stuck with it, at least up until now. The fact that it is such a small factor, existing reimbursement policy, what you are saying is that even if we do not allow the revaluation of assets, that your corporation and those similarly situated are going to be using other economic principles in determining whether or not you are going to merge or have acquisitions. So that no matter what this committee would do, we can rest assured that you would do what is in the best interest of the patients. No problem there; right?

Mr. HOWARD. That is right.

Chairman RANGEL. And so the only problem that we have to deal with is how you could explain to us as we make the change—and change we will make—as to why, just because a corporation involved in the delivery of health care is acquired by another institution, in an accounting transaction where you have not changed nurses, you have not changed hospitals, why does the patient reimbursement rate, from the Federal point of view, soar as dramatically as those on the charts that they brought in this morning?

Mr. HOWARD. Mr. Chairman, with respect to the charts that we saw this morning, I do not believe I can comment because I do not know the specifics.

Chairman RANGEL. Well, forget about the charts and respond to the evaluation that when these mergers occur costs increase based on accountants' methods of depreciation. While it is disputed by your testimony as to whether or not the medicare reimbursement is the reason for mergers, it is not disputed that the cost per patient drastically increases where it is entirely unrelated to the staff and other types of costs.

Mr. HOWARD. Mr. Chairman, with respect to hospital reimbursement of depreciation expense associated with the original cost of the hospital, those costs that are paid by the patients currently in the hospital before the sale of a hospital really tends to understate the replacement cost of that hospital. It is only in some selected States—I believe Maryland is one of them—where they tend to reimburse in terms of the rate-setting at a better approximation of what I would consider to be the replacement cost of that particular hospital.

Chairman RANGEL. Let me try it again, because I did not state my question correctly. I am in hospital A. I know what my costs are per day. I am informed by the administrator of the hospital that hospital A has now merged with hospital B, and as a result of the low depreciation rate that my hospital had that there is going to be a dramatic increase in my cost, even though my doctors have not improved, the nurses have not improved, nothing has improved except the accountants got together and found out that my per diem day was underevaluated because of the depreciation rate of hospital A.

Mr. HOWARD. What I was trying to say, Mr. Chairman, was that the cost prior to the day of acquisition tended to be low in terms of

depreciation and interest because it does not reflect the reproduction cost of that particular facility. That is what I was trying to indicate.

Chairman RANGEL. Well, who pays for that dramatic increase?

Mr. HOWARD. Who pays for that dramatic increase? Patients of the hospital subsequent to the merger, to the extent that there are increased charges. However, to the extent that the increased deprecation and interest is offset by efficiencies brought about by the merger over time, which in the case of some of the acquisitions does take place, and to the extent that there are improved capital expenditures in that particular hospital that takes place over time—all of this has to be taken into account when you are looking at the price the patient is charged or pays subsequent to an acquisition. You cannot look at just one particular instance.

Chairman RANGEL. OK. But in the short run it is the Federal Government.

Mr. HOWARD. In the short run it is the Federal Government that begins to pay for its share on behalf of medicare patients immediately, because the Federal Government's capital reimbursement system is on a cost reimbursement basis. The private insurance system tends not to be on a cost reimbursement basis. It is on the basis of prices.

Chairman RANGEL. Well, since the gain is going to be over the long run and since your decisions are based on the long run, if we pull the Government out in the short run, nobody should be offended by us taking that posture.

Mr. HOWARD. I do not believe that you will have a significant adverse impact on hospital industry acquisitions, as I stated earlier, but I think because we are anticipating a report in about 7 or 8 months, it might be prudent to just wait and get the report and deal with the full capital issue as the Congress had intended to before.

Chairman RANGEL. Well, we are dealing with our budget now, and so we do not have the luxury with a 2-year term to see the results of the long run. But if we make a mistake, certainly those of us who come back would be in a position to correct it.

Thank you.

Chairman JACOBS. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

Mr. Howard, you have made a very important point in talking about the inadequacy of depreciation allowances based upon historic cost in providing funds for replacement. I understand that. I am just not convinced that the system we have now is the way to correct it. Let me take that point and pursue it with you.

If hospital A, which costs $10 million, is sold to hospital B for $20 million, $20 million, as long as it is not in excess of replacement cost, becomes the basis for reimbursement under medicare and certain other programs. But the money does not go to B, in effect; B has paid $20 million to A, and A presumably wants to get out of the hospital business because they sold the hospital from A to B.

Now, how are you increasing the funds for replacement of hospitals and having a fund at an adequate level under this circumstance where the increased payment does not really stay with the

purchaser? It has already been passed on at the very beginning to the seller.

Mr. HOWARD. But what the purchaser is allowed to do, Mr. Congressman, is to fund, if he so desires his depreciation reserve to provide for the replacement of that particular facility based on the new price and the reproduction cost of the facility that he purchased. The $10 million or $20 million does go to the original purchaser who, in turn, if he is a tax-paying institution, pays a capital gains tax on it which is maybe 25 percent of the difference between $10 and $20 million.

Mr. GRADISON. But the buyer has paid $20 million at the beginning, and over the term of the depreciation merely recaptures in dollars, if you totally fund this account, what they paid out in the first place.

It seems to me if we are setting out to have a system for recognizing the true cost of replacement that we surely would not do it by saying that it only goes to those who are involved in affected statutory mergers, even certain combinations that can take place today where you do not get the increase. It is a fluke. Maybe it is a matter of accounting principles and legal principles, but it certainly is not related to the economic problem, which is a real one, I acknowledge, of how to replace these facilities. You have leaned very heavily on that point.

I think there is a lot to your concerns on it, I really do, but I just do not see how the present system of reimbursement accomplishes the goal which you set out.

Mr. HOWARD. Let me put it this way, sir. The Government, in its wisdom, constructed a number of hospitals early on with Hill-Burton money. Those hospitals did not change hands. There is not adequate reimbursement to replace those facilities. If you get ready to replace them with Federal money or whatever sorts of money, you have got to come up with the reproduction cost of those particular facilities. When those facilities change hands, if they change hands to a private institution or investor-owned hospital, we expect to be reimbursed by the Government on a replacement cost basis. We anticipate from our payors or at least from the patients that we serve, medicare and private patients, enough funds to provide a better approximation of replacement cost than was originally in that first—in the original cost of that Hill-Burton hospital.

We tried to do it starting with the date of the acquisition as opposed to waiting until 40 years later and trying to come up with the funds, as would have to be done if the hospital was not acquired. They have got to replace it at some point in time, and it is better to, at least in my opinion, when it changes hands, to provide a better approximation of that replacement cost in terms of patient recovery over time than to simply do it at one point in time.

Mr. GRADISON. Mr. Howard, you made the point several times that there were some people supporting this moratorium who were opposed to mergers and acquisitions. I am not among them. I do not know anyone, frankly, that I have spoken with who is opposed to mergers and acquisitions, nor have we heard any evidence that mergers or acquisitions should be discouraged by a moratorium.

What we have heard is questions as to whether those acquisitions and mergers might take place at lower prices than the other ones would take place at. I am a little surprised on where you come out here. I would think your institution as an acquirer of hospitals, on balance would benefit from the prospective moratorium in that it would make it possible for you to purchase facilities at lower prices than you would have to pay today.

Mr. HOWARD. Mr. Congressman, we generally are probably more a constructor of hospitals than an acquirer of hospitals. In 1983 out of about a $700 million capital expenditure budget, only $16 million was spent on acquisition of hospitals. The rest was spent for the construction of new hospitals, expenditures associated with Hospital Affiliates' hospitals, upgrading them, and expenditures associated with providing new and improved services to the hospitals where we currently operate. We only spent $16 million on acquisitions.

Mr. GRADISON. I wonder if you could answer the question, which is, would it not be possible for you to make acquisitions at lower prices if there were a moratorium on revaluation?

Mr. HOWARD. I believe that the price would not significantly change because of two other programs—the certificate of need and the 1122 programs. I think that those programs probably contribute more to the excess of price over reproduction cost than does the medicare policy change.

Mr. GRADISON. Mr. Chairman, in the report of the General Accounting Office one of the most disturbing things which they pointed out had to do with this question of the activities of independent appraisers. In particular, the General Accounting Office questioned the independence of the appraisers in their accuracy. And now I am quoting: "Because at HCA's request, the appraiser changed the values assigned to building services equipment after completing the initial appraisals."

This question of the independence of appraisers is pretty important. Being a businessman, I can understand getting an appraisal report and disagreeing with it and using other figures. However, in the comments which were made by HCA with respect to this point, there was no denial that the HCA did go to the appraiser prior to the completion of this appraisal and requested the appraiser to reallocate certain values in a way which, when all the underbrush is cleared away, had the effect of increasing the potential reimbursement under Medicare.

I wonder if you could comment about this matter. Is this a general practice of yours to go to appraisers in instances like this before you receive their appraisal report, or is this the only instance where it ever happened?

Mr. HOWARD. Mr. Chairman, the appraisers that we use for our hospital acquisitions are independent of HCA. The one in this particular case is one of only four that we have used from time to time to perform appraisals, and the appraisals that these institutions provide to us are available to the intermediaries, to HCFA and anyone else that deems them appropriate.

In this particular instance, my recollection of this situation is that the appraiser submitted some documents to us in preliminary form. The accountant asked for some consistency with respect to

the way we had been accounting for building service in hospitals in the past. This particular type of equipment— I think it was $100 million worth of building service equipment—we normally considered as part of the building and not as equipment which has a shorter life for depreciation. In other words, our independent accountants recommended that we classify this particular equipment as part of the building, which reduces the amount of depreciation that would be claimed in any one given year. The total value of the appraisals did not change.

So it tends to have just the opposite effect for that particular change than I think was indicated by you. But it was not HCA; it was actually the accountants that wanted to make sure that there was consistency in accounting policy.

Mr. GRADISON. It was your independent accountants?

Mr. HOWARD. Our independent accountants.

Mr. GRADISON. Your independent accountants went to the independent appraiser?

Mr. HOWARD. I am not sure, sir, because I was not at the meeting, but there was consultation between the parties in reviewing that particular preliminary report.

Mr. GRADISON. Is this the only example of this kind of contact with an appraiser before the report is finished that you know of in terms of the activities of Hospital Corporation of America? Are there any others that you know of?

Mr. HOWARD. There are none other that I know of at this time. I can check it out if you would like.

Mr. GRADISON. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Pickle.

Mr. PICKLE. Thank you, Mr. Chairman.

Mr. Howard, it seems to me that you are taking the position that the buying and selling of property is a recognized method of doing business in this country and that we encourage it, and partially so because of the depreciation that one entity or one company might get by virtue of a merger or acquisition.

I take it you are saying that the same principle ought to apply to hospitals as well as in regular business, and we ought not penalize you, that you ought to be treated the same as others. Essentially I guess that is point.

Mr. HOWARD. Yes.

Mr. PICKLE. Well, I think it is a good point.

I think there is a policy question in there at some point because in addition to the regular bases and deduction of interest that a normal business can get, you can additionally get some reimbursement through medicare.

Now what concerns me about your statement is that you contend this does not give you an advantage. It does not increase materially the cost of the hospital per patient care, and these costs are mostly neutral, as you have concluded, and this is a very small cost to the medicare program.

And yet this morning we had testimony from the GAO, from HHS, from the Inspector General and from HCFA that says just the contrary. Now it disturbs me that you would contend that it is not an increased cost and yet all of our Government agencies say it is a very marked cost. I simply say to you that I have to ask our

staff to make an indepth study of this because somebody is right and somebody is wrong.

Now I take it you are not in this business at HCA of buying hospitals just for your health—maybe your business health, but not your personal health or an individual's health. And if it was not a very profitable business, you would not be in it.

I am convinced also that HCA and other private hospitals render a great service by revitalizing and making new almost an old hospital that would go out of business. But somewhere in between these facts is the real facts and the truth, and I think that is what we have to look at here.

I hope that the study is completed here within the next few months and will give us a clearer evaluation of what are the real costs on it because I think that is what this committee is looking for and I assume that you would be agreeable, not only agreeable, but I think that would be a reasonable approach.

It just seems to me that there are increased costs and we have got to recognize that and try to find an answer to it.

Thank you, Mr. Chairman.

Chairman RANGEL. I think some place in the statement Mr. Howard was referring to an increase in the State and Federal taxes that was not considered by the General Accounting Office. Am I correct?

Mr. HOWARD. Yes, sir. There was about $25 million that was paid by INA Corporation, which sold the corporations, to various States in which its hospitals operated.

Chairman RANGEL. And so there would be capital gains?

Mr. HOWARD. Capital gains taxes, yes, sir.

Chairman RANGEL. Now could you tell me, since you are intimate with this transaction, to what extent did your corporation have to borrow the money to acquire these hospitals?

Mr. HOWARD. We did borrow money to acquire the hospital. It was a combination of borrowed funds——

Chairman RANGEL. I mean percentage of dollars.

Mr. HOWARD. We issued stock of about $200 million and borrowed approximately $700 million to acquire the hospitals.

Chairman RANGEL. Now the reason I asked that, since we are getting involved and it sounds like we are writing up a tax bill here, that every time we seek to close up one hole somehow we lose revenues someplace else. And so Chairman Rostenkowski always says that we have to prove that a change is revenue-neutral.

So while accepting the capital gains taxes that go to the State and Federal Government, with an $800 million loan, just how much of that interest do you write off, which we, unfortunately, have to include as a revenue loss?

Mr. HOWARD. Well, on the particular transaction that you are talking about, the $55 million figure—which represented the increased costs on an annual basis—does include the interest. It includes interest I think in some cases at an approximate average of about 16, 16.5 percent at the time. Those interest rates have come down.

Chairman RANGEL. But we are involved in the reimbursement of those rates, too.

Mr. HOWARD. You are involved in reimbursement of those rates. If one was to, however, take the $135 million in capital gains taxes, if we would deem it so appropriate to invest it at the current rates of about 10 percent, about $13.5 million would come to the Federal Government 1 year, too.

Chairman RANGEL. Well, I think that as long as it is as unclear as to what is the existing rule and regulation certainly your corporation should be given the benefit of the doubt, but since it is abundantly clear that we have to budget the increased cost of reimbursement, we are going to look to see how we can reduce those costs. We are going to do it this year, next year, and probably as long as we are here.

Meanwhile, in order to avoid this type of allegation that mergers and acquisitions are taking place in order to take advantage of reimbursement rates, it would be helpful to see if you can think of how the Government can encourage replacement value without getting involved in these type of formulas. We find it very, very difficult to explain to our constituents, these dramatic increases in costs where they should expect some benefits in the long term.

Mr. HOWARD. I agree, Mr. Chairman, and I think that what we can propose to do is to work with you between now and the next year or so as you consider the capital issue to try to incorporate this concept of replacement value into the new capital formula that you will introduce into the DRG in October 1986.

Chairman RANGEL. I would appreciate it if you could suggest something concrete to get us out of this area because it is clear to us that the General Accounting Office report standing alone presents real, deep-seated political problems.

Mr. HOWARD. We offer any help that you need, sir.

Chairman RANGEL. Thank you.

Mr. Gradison?

Mr. GRADISON. No further questions, thank you.

Chairman RANGEL. Our next witness is Morton Hyman, vice chairman of the New York State Public Health Council, and former vice chairman of the New York State Health Planning Commission. He is testifying on behalf of the New York State Department of Health, which really does not have these types of problems because of their foresight in understanding the importance of cost containment.

We thank you for the leadership which you have shown the Nation and we welcome your testimony—that is, a summary of it.

**STATEMENT OF MORTON P. HYMAN, VICE CHAIRMAN, NEW YORK STATE PUBLIC HEALTH COUNCIL, FORMER VICE CHAIRMAN, NEW YORK STATE HEALTH PLANNING COMMISSION, ON BEHALF OF THE NEW YORK STATE DEPARTMENT OF HEALTH**

Mr. HYMAN. Thank you very much, Mr. Chairman. I am Morton Hyman. I am testifying as a private citizen on behalf of the State of New York. I appreciate the opportunity to be with you today to share with you New York's views and its experience concerning capital cost reimbursement.

In the early 1970s New York began to experience a marked increase in requests for approval of sales and leases of health care

facilities, mainly nursing homes. The sales prices were significantly higher than the original approved capital costs and the rentals under the leases were higher than the capital reimbursement would otherwise have been.

We found ourselves in the curious position of increasing medicaid capital reimbursement for a facility from one day to the next merely because a real estate transaction had taken place. We also saw that sales prices and rentals were being determined by the maximum amount which would be recognized for reimbursement purposes without regard to what a facility could earn or any other economic standard.

In numerous cases when the Public Health Council, which has the certificate of need jurisdiction in New York, objected to a price being too high, it was reduced to a level deemed acceptable for reimbursement purposes. In other words, Mr. Chairman, reimbursement established price and value and not the marketplace.

Accordingly, we reached certain conclusions in New York. First, that the increase in capital reimbursement occasioned solely by a sale or lease did not provide a single attendant benefit to health care or its delivery. It did not result in one additional hospital or nursing home bed, the provision of one additional physician or nurse, or indeed one iota of increased or improved health care services. In short, the State would receive no value for increased reimbursement.

Second, increased reimbursement on a sale or lease created incentives for transfer of facilities and to traffic in certificate of need approvals. It also penalized those operators who remained with their facilities and who were dedicated over the long term to providing care since their capital reimbursement would not increase correspondingly.

Third, with limited resources available for health care, allocating preferential capital payments to those who sold, bought and leased would significantly reduce moneys available for patient care and for the large majority of the State's health care delivery system.

Finally, medicaid provided reimbursement for the entire original approved facility project cost, together with interest on moneys borrowed to finance the project, and, for proprietors, a return on their equity investment—a complete 100 percent payback with an attractive return on investment over a determined useful life of a facility.

If New York increased reimbursement by recognizing a sales price or rental in excess of the original depreciated cost, the State would be paying more than once for a facility without any benefit to the State.

Accordingly, in March of 1975 New York State adopted a simple rule. medicaid capital cost reimbursement components for depreciation, interest and return on and of equity would not change as a result of a sale or lease of a facility. The rule is founded on certain principles which are set forth in the report of the Public Health Council, which I would ask permission, Mr. Chairman, to submit into the record.

The State should pay only once for a facility. Reimbursement should be related to the delivery of health care services and not be dependent upon real estate transactions. Excessive reimbursement

should be eliminated, particularly where it is totally unrelated to improvement of either the quality or quantity of health care services delivered.

Similar facilities should receive similar reimbursement and delivery of health care services is not best served by inducing through potential of economic gain frequent transfers.

A highly vocal opposition consisting primarily of nursing home owners warned that the change in the rule governing capital cost reimbursement would foreclose additional private capital investments, that nursing homes would disappear from the system and be put to alternate nonhealth care uses, that a shortage of nursing home beds would result and that the rule was unfair and illegal.

In fact, Mr. Chairman, New York has substantially met its determined need for conforming nursing home and acute care beds in almost every area of the State. Nursing homes have not gone out of the system. Private capital has not been discouraged from entering the nursing home industry; there are today currently pending applications for requests for approval from proprietary sponsors of over $250 million for new nursing home beds, even though the need has basically been met.

As to the issue of fairness, we believe that setting sales prices and rental payments are properly the province of the contracting parties. However, the parties are recipients of a public franchise in the certificate of need approval that creates a protected environment and demand for services by limiting competition.

The facility is paid for and supported substantially by public moneys. This is not a free market or private enterprise. Under such circumstances, it is New York's view that it is necessary and proper for the State to determine what costs it will recognize for purposes of reimbursement and to place reasonable limitations on the amount of gain which the State will pay through reimbursement.

The concept of limiting gain as well as the New York rules were reviewed in detail and upheld by the United States District Court for the Eastern District of New York, with unanimous affirmance by the U.S. Court of Appeals for the Second Circuit, and I would like to submit that decision as part of the record, Mr. Chairman.

Mr. Chairman, for nearly a decade the State of New York has maintained that——

Chairman RANGEL. Excuse me. How long is that decision?

Mr. HYMAN. The district court decision runs about 35 pages and the appellate decision runs approximately 3 pages.

Chairman RANGEL. Suppose we keep that in the files for the record rather than in it.

Mr. HYMAN. Mr. Chairman, for nearly a decade the State of New York has maintained that medicaid capital cost reimbursement will not change merely because of a sale or lease of a facility. As a result, New York has effected substantial savings and has added stability to its health care delivery system.

We believe that this simple rule, if applied to medicare and to medicaid nationwide, would achieve significant cost savings for the Nation's health care system, thereby providing greater resources for patient care without adversely affecting or curtailing entitlements, benefits, or services.

Thank you, Mr. Chairman.
[The prepared statement follows:]

STATEMENT OF MORTON P. HYMAN ON BEHALF OF THE STATE OF NEW YORK

Thank you, Mr. Chairman. I am Morton P. Hyman, a private citizen, appearing on behalf of the State of New York. I have served on the New York State Public Health Council, of which I am presently Vice Chairman, for over 12 years. The Council has jurisdiction over and must approve all transfers and leases of health care facilities. I have also served as Vice Chairman of the New York State Health Planning Commission and as Chairman of various State task forces and committees dealing with Medicaid Capital Cost Reimbursement. I also serve on the Boards of Trustees of two major teaching hospitals in the City of New York. I appreicate the opportunity to testify here today and to share with you New York's views and its experience concerning capital cost reimbursement.

In the early 1970's, New York began to experience a marked increase in requests for approvals of sales and leases of health care facilities, mainly nursing homes. The sales prices were significantly higher than the original approved capital costs and the rentals under the leases were higher than the capital reimbursement for the original project cost would have been.

We found ourselves in the curious position of increasing Medicaid capital reimbursement for a facility from one day to the next merely because a real estate transaction had taken place. We also saw that sales prices and rentals were being determined by the maximum amount which would be recognized for reimbursement purposes, without regard to what a facility could earn or any other economic standard. In numerous cases, when the Public Health Council objected to a price as being too high, i.e., too expensive for the system, the price (or rental) was reduced by the parties to a level deemed acceptable for reimbursement purposes. In other words Mr. Chairman, reimbursement established price and value, not the marketplace.

Upon analysis of what was transpiring, we reached certain conclusions:

1. The increase in capital reimbursement occasioned solely by a sale or lease did not provide a single attendant benefit to health care or its delivery. These expenditures did not result in one additional hospital or nursing home bed, the provision of one additional physician or nurse, or indeed one iota of increased or improved health care services. In short, the States would receive no value for the increased reimbursement. (Operating efficiencies which were sometimes claimed should be recognized appropriately in the operating reimbursement component and incentives for such efficiencies should be available to all facilities without regard to a sale or lease).

2. Increasing reimbursement on a sale or lease created incentives to transfer facilities and to traffic in certificate of need approvals; it also penalized those operators who remained with their facilities and who were dedicated over the long term to providing care, since their capital reimbursement would not increase correspondingly.

3. With limited resources available for the health care system, allocating preferential capital payments to those who sold, bought and leased would significantly reduce monies available for patient care and for the large majority of the State's health care delivery system.

4. Medicaid provided reimbursement for the entire original approved facility project cost, together with interest on monies borrowed to finance the project, and, for proprietors, a return on their equity investment; a complete 100 percent payback with an attractive return on investment over a determined useful life of a facility. If New York increased reimbursement by recognizing a sales price (or rental) in excess of the depreciated original costs, the State would be paying more than once for a facility, without any benefit to the State or the system.

Accordingly, in March of 1975, New York State adopted a simple rule: Medicaid capital cost reimbursement components for depreciation, interest and return on and of equity would not change as a result of a sale or lease of a facility. This rule is founded on the following principles developed by the New York State Public Health Council [1] in October of 1974:

1. The State should pay for a facility only once.

2. Reimbursement must be reasonably related to the delivery of health care services and not be dependent upon real estate transactions and changes in ownership.

[1] Copy of the Report of the Public Health Council is attached [omitted here].

3. Excessive reimbursement must be eliminated, particularly where it is totally unrelated to improvement of either the quality or quantity of health care services delivered.

4. Similar facilities should receive similar reimbursement without regard to subsequent transfers or leases.

5. Delivery of health care is not best served by inducing, through the potential of economic gain, transfers of health care facilities.

A highly vocal opposition, consisting primarily of nursing home owners, warned that the change in the rule governing capital cost reimbursement would foreclose additional private capital investments, that nursing homes would disappear from the system, and be put to alternative non-health care uses, that there would be a serious shortage of nursing home beds, and that the rule was unfair and illegal.

In fact, Mr. Chairman, New York has substantially met its determined need for conforming nursing home and acute care beds in almost every area of the State. Nursing homes have not been taken out of the health care system for other uses. Private capital has not been discouraged from entering the nursing home industry in New York; there are pending currently from proprietary sponsors requests for approvals of over $250 million for new nursing home beds.

As to the issue of fairness, we believe that setting sales prices and rental payments are properly the province of the contracting parties. However, the parties are recipients of a public franchise (certificate of need approval) that creates a protected environment and demand for services by limiting competition. The facility is paid for and supported substantially by public monies. This is not free market private enterprise. Under such circumstances, it is New York's view that it is necessary and proper for the State a) to determine what "costs" it will recognize for purposes of reimbursement and b) to place reasonable limitations on the amount of gain which the State will pay through reimbursement.

This concept of limiting the gain as well as the New York State rules were reviewed in detail and upheld by the U.S. District Court for the Eastern District of New York, with unanimous affirmance by the U.S. Court of Appeals for the Second Circuit (*Hempstead General Hospital et al* v. *Whalen et al*,[2] quoted at length in the OIG Office of Audit, Kansas City Regional Office Preliminary Audit Report of September, 1983 pages 19–22).

Mr. Chairman, for nearly a decade the State of New York has maintained that Medicaid capital cost reimbursement will not change merely because of a sale or lease of a facility. As a result, New York has effected substantial savings and has added stability to its health care delivery system. We believe that this simple rule, if applied to Medicare and to Medicaid nationwide, would achieve significant cost savings for the nation's health care system, thereby providing greater resources for patient care, without adversely affecting or curtailing entitlements, benefits or services.

Thank you, Mr. Chairman.

Chairman RANGEL. Let me thank you for your remarks.

Mr. Gradison?

Mr. GRADISON. I have no questions. I would like to thank the witness for coming down here. This is extremely helpful to find out that such a large State has tried this approach and found that it works.

Mr. HYMAN. Thank you.

Chairman RANGEL. Mr. Chairman?

Chairman JACOBS. No questions.

Chairman RANGEL. Let me thank you, because representing the city and State of New York down here in Washington is very difficult. Of all the problems in the Nation we sometimes have them in greater degree, but in the area of health delivery and cost containment it has made me proud to be a Member of Congress to see so many of my colleagues emulating the progress that New York has made in this area. Certainly your testimony today is living proof that we can have acquisitions, we can improve the quality of care,

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[2] Copies of the District Court and Court of Appeals decisions are attached [omitted here].

and we do not have to necessarily have the medicare reimbursement increase that dramatically.

So to your colleagues please share with them that we deeply appreciate what sometimes in New York State, I know, appears to be a very thankless job. We are very appreciative of the progress that you are making in this area.

Mr. HYMAN. Thank you very much for your generous and gracious comments.

Chairman RANGEL. The next witness is Mr. David Bausch, vice chair, Health and Education Steering Committee, National Association of Counties. I believe Mr. Bausch is the county executive of Lehigh County in Pennsylvania.

**STATEMENT OF DAVID BAUSCH, COUNTY EXECUTIVE, LEHIGH COUNTY, PA., AND VICE CHAIR, HEALTH AND EDUCATION STEERING COMMITTEE, NATIONAL ASSOCIATION OF COUNTIES**

Mr. BAUSCH. Good afternoon.

Chairman RANGEL. Good afternoon. Your full statement will appear in the record. You may summarize and proceed as you feel most comfortable. Thank you.

Mr. BAUSCH. First of all, I will identify myself not only as an elected official, but as a representative of NACo in our concerns for health care. I began as a corpsman in the Air Force during the Korean war. I served as an assistant administrator of a hospital, an administrator of a public hospital, and also administrator of an 800-bed nursing home facility operated by the county, county commissioner, and now I am county executive.

Chairman RANGEL. When were you in Korea?

Mr. BAUSCH. In 1950.

Chairman RANGEL. What outfit?

Mr. BAUSCH. I was in the Air Force, sir.

Chairman RANGEL. Oh. I was in the Second Infantry Division. I guess it was a lot of difference with the Air Force.

Mr. BAUSCH. Yes, it was. I just want to clarify—I have been on both sides of the desk—as a worker in health care and also as a provider.

Chairman RANGEL. Very good.

Mr. BAUSCH. I am here to speak today on the role of the Nation's counties in health care and how this role may be seriously impacted by the recent rapid growth of proprietary hospitals, nursing homes, and investor-owned health care chains.

Chairman RANGEL. Sir, if you could speak directly in the mike, it would help us up here.

Mr. BAUSCH. All right.

Chairman RANGEL. Thank you, that is great.

Mr. BAUSCH. The burgeoning growth of for-profit facilities represents a significant new direction in health care in the United States and is a public policy issue worthy of objective study and analysis. NACo commends this committee for taking the lead by holding hearings on this most important issue. We thank you for this opportunity to present our views before you today.

Central to any debate about the impact of mergers and acquisitions among the proprietary sector on health care costs is the issue

of how this trend affects the public health system. In light of a growing indigent population—the elderly, children and unemployed—it is most important for public officials at all levels of government to actively ensure that the health needs of this population will continue to be met.

A new emphasis on reimbursement analysis and an increasing shift of nonprofitable services from the for-profit sector to the public sector has serious implications. These include legal implications for access and quality of care for all Americans due to financial problems or sell-outs of public providers and, two, financial implications for counties and other local public providers due to limited revenue/reimbursement and a lack of access to capital for replacement and improvement of facilities.

The issues I will speak about today on behalf of the membership of NACo show the need for several coordinated nonpartisan actions if we wish our Nation's public health system to survive. NACo presents these proposed actions in the form of several strong recommendations.

One: the first and most important recommendation must be a serious Federal commitment to the provision of public health care in this country. Vital to this commitment must be: (*a*) no further reductions of financial support to present public health care programs; and (*b*) a Federal financing of indigent care programs.

Specific needs include a rethinking and revitalization of medicaid, medicare authorization to provide for alternative forms of long-term care such as homemaker care, health insurance for the unemployed, charity care pools, and/or grant programs for public hospitals.

Two: regulation of the for-profit sector where practices infringe on the public trust. This must include enforcement of no-dumping provisions in current law to ensure that proprietary hospitals and health care facilities treat the indigent and the needy who come to their doors; refinement of Federal regulations where certain provisions reward providers without specific commitments to public care.

One example is capital pass-throughs presently allowed under medicare. Such pass-throughs of capital costs may enhance the marketing of a facility without ensuring quality or quantity of care to medicare patients.

Three: a sincere effort to contain costs, without cost-shifting to local level public care. This should include: (*a*) technical asssistance and funding to counties to develop or participate in, one, prepaid area-wide health plans; two, home health services and other alternatives to institutional care for those not needing institutional care.

I can comment that many counties, including my own, are pursuing such alternatives now. Assistance rather than funding reductions would move counties and the entire health care delivery system toward these important changes for the future.

Four: a Federal commitment to assist public hospitals to obtain access to capital. The National Association of Public Hospitals has made several recommendations, including credit enhancements, direct grants to public hospitals, and greater flexibility in the tax code. These comments can be made available to you upon request.

It is an accepted fact that counties play an important part in our public health care system. As providers, financers, planners and purchasers of health services, counties in one way or another have a role in addressing the health care needs of virtually all Americans.

Collectively counties also have a special role nationwide in serving to meet the health needs of indigent citizens. In the majority of States counties are legally responsible for indigent health care or all unreimbursed health care costs.

Due to the rapidly rising cost of health care goods and services and the cost containment measures in public assistance and public health programs by the Federal Government and most States, overall health care expenditures by counties are on the increase.

Of the 1,900 public hospitals in this country, over 900 are directly affiliated with county government. Public hospitals provide a health safety net for the elderly poor who have unmet needs, children of the working and nonworking poor, and the new poor among the unemployed who have lost their health benefits but who do not qualify for medicaid or other forms of assistance.

Counties also own and operate over 600 nursing homes, and carry out the multiple responsibilities that contribute to the long-term health care needs of our Nation's growing elderly population, including medicaid, the Older American's Act, home health care and title XX services.

Over 2,000 county health departments operate, fund, and provide basic public health services, from rodent control, flouridation and emergency medical services to maternal and child primary health care and rape prevention.

Local revenues support the provision of county health services for millions of Americans who have no health coverage. In 1982, counties spent over $22 billion on health care. The largest public hospitals provided close to a billion dollars in nonmedicaid charity care in 1980 and about 25 percent of these large public hospitals are county-owned.

County public health facilities are in trouble. The next several years may well determine if equal access to health care for all citizens is possible or if a person's individual assets will become the criteria for adequate health care access. NACo believes that we have reason for great concern, since there are many indicators that the very survival of our public health system in the United States is at stake.

We know that public hospital and nursing home sales or closures are on the increase. In fact, a recent example of growing financial problems for the public hospitals in North Carolina, and increased interest by proprietary health care chains to purchase these hospitals, prompted the 1983 State General Assembly to temporarily stop the sale of county and city hospitals to companies owned by investors.

Wayne County, Mich., Cuyahoga County, Ohio, and Polk County, Iowa are but a few of the many counties struggling to keep their hospital doors open. All three jurisdictions are densely populated, have high unemployment and subsequently represent many uninsured people whose health care they must assist in paying for.

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May I briefly describe other similar examples of the public health crisis in counties across the country.

In 1983, Hennepin County, Minn. determined that their medically-indigent population—those who do not qualify for medicaid but have no health insurance—had increased and continued to climb. These people receive some medical care through county general assistance supported by local taxes and some State dollars.

Other county statistics point to sharp increases in eligible 18 to 21-year-olds in the federally-funded medical assistance only children's program. The county suspects this sharp increase is due to high unemployment. The county also completed a survey last year of the effect of Federal/State limits upon reimbursement where people have lost their comprehensive health coverage. They found that over 30 percent of the respondents stated that they were deferring all medical care.

In Texas, where unemployment reached 10.5 percent last year, Harris County saw a 12 percent increase in indigent outpatient care. County officials estimated that at least two-thirds of this increase has been directly related to unemployment. In 1982 over two-thirds of the county hospital's $150 million budget went to provide some form of charity care.

New York State has been forced to close or substantially decrease many services provided at inpatient mental health care facilities. Chatauqua County notes that at the same time that the stress of unemployment has led to a rise in requests for mental health services the county and other service providers are suddenly being inundated with former inpatients of State facilities.

Unfortunately, similar examples to these described abound in counties across the Nation. Economic recovery will not alone stem the tide of additional public health care burdens.

I am going to jump to page 9, if you are following somewhere in the testimony.

Chairman JACOBS. Mr. Bausch, before you make that leap, I think maybe we had better recess just for a couple of minutes to go over and answer this quorum. We shall return presently.

Mr. BAUSCH. All right, fine.

[A brief recess was taken.]

Chairman JACOBS. Mr. Bausch, I express my regrets. Please continue.

Mr. BAUSCH. There has been a trend in recent years to speak of a health care marketplace and beneficial competition between health care providers as a way to hold down costs.

While there are some obvious benefits to the health care consumer of having choices in health care, it is also important to recognize that our national health programs, medicare and medicaid among them, have created strong incentives and disincentives that influence the marketplace.

As a result, some patients and some illnesses are generally less desirable choices in the for-profit sector. They are simply not profitable, and the wise businessman would prefer to market beds, care and billing to other clients.

The public health sector, on the other hand, does not have an entrepreneurial choice. By moral, social, political and legal obligation our countries, as public health providers, willingly shoulder this

burden. This has been a practice long accepted and few would argue the need for counties and other public providers to give this care.

I must note before continuing that I am not arguing against the need for efficient provision of health care services in both the public and private sector. The questions we are addressing today have more to do with national ethics and fiscal reality than cost efficiency.

Studies are now showing that it is not unusual for investor-owned hospitals to charge more than a public hospital for similar services. Of more concern are certain specific instances of an active avoidance of admissions for indigent or otherwise unprofitable patients. NACo has copies of two maps purportedly used by proprietary hospitals to send undesired patients to county facilities. A question we must ask is: where will these patients be sent if these public health facilities are sold or are closed?

To further discuss cost efficiency in contrast to business efficiency, a study by Blue Shield of North Carolina has shown that proprietary claims for three routine surgeries were 20 percent higher than public health claims. This study precipitated the recent action by the General Assembly to place a moratorium on the sale of county and city public health hospitals mentioned earlier. NACo has attached copies of the study for the record.

In addition, a study of California hospitals recently published in the New England Journal of Medicine concluded that for-profit hospitals were not more efficient, actually cost more, and refrained, when possible, from treating indigent and uninsured patients.

NACo has conducted a survey of State attorneys general nationwide which asked for a review of the ultimate legal responsibility within each State for unreimbursed, indigent patient care costs. We have received responses from over half of the States surveyed. Of those, the majority of States have laws which hold counties liable for unreimbursed health care costs.

Where counties are legally liable for indigent care, the loss of control over the provider hospital or nursing home poses a serious potential threat to access to health care. While counties are more inclined to sell or close facilities due to cutbacks in Federal or State funding assistance, those very cutbacks will ultimately impede counties' ability to meet indigent care costs in alternative private settings.

I must add that new limits in medicare and medicaid versus a steadily increasing population of at-risk elderly will exacerbate this situation further in most counties.

I can mention some recent developments in my home State of Pennsylvania as a detailed example. Pennsylvania counties have traditionally played a major role both legally and conceptually in public nursing home care. Forty-four of 67 counties presently provide some form of public nursing home services.

Although county homes are only the third major provider of long-term care beds in our State, behind proprietary and nonprofit facilities, county homes are the No. 1 provider of medicaid long-term care beds.

Fully 91 percent of all bed days in these county facilities are provided to medicaid patients. Admission information shows that counties accept primarily the long stay, nondischargeable patient with multiple health problems. This patient also has very limited financial assets by the time he or she comes to our facilities.

Some recent trends are quite disturbing. In part due to a recent redefinition of care statewide, two counties have opted out of the skilled nursing care program in the last year and a third county is contemplating doing the same. One county has simply closed down beds in all levels of care.

In the past 5 years almost one-quarter of the counties have converted to management contract operation through proprietary firms. Another recent trend is to farm out county home ancillary services such as physician contracts, physical therapy, pharmacy, laboratory and clinical services, and medical supply services to private vendors.

These vendors directly bill medicare for reimbursement. Normally this reimbursement is higher than the county home would receive if they provided the services with their own staff. This separate billing, however, is also more costly to medicare and also to the consumer, but does provide a fair profit to the private vendor.

Pennsylvania county homes continue to accept a heavy burden of truly indigent patients in addition to the medically needy. The medically needy have often spent down their lifelong assets in a nearly proprietary facility before discharge to the county home.

Our communities and citizens appear to have accepted the tacit understanding that in order for proprietary facilities to make a profit they must limit the number of medicaid beds they provide. However, this understanding does mean an increasing burden on county taxpayers.

When a new proprietary home has opened in the past, the home would often accept a high percentage of medicaid patients just to initially fill beds. That percentage has dropped precipitously once private pay admissions have been found.

You may not be surprised to hear that nationwide nursing home chains have found Pennsylvania to be a fertile ground for acquisitions. One chain that recently came into our State has grown from a small number of homes to over 700 in less than a decade. Even the Leader Homes, a well-run Pennsylvania chain of 21 homes, has recently been bought by a larger nationwide proprietary chain.

I hope that my personal comments help to clarify the subtle yet consequential interaction between medicaid and medicare funding, State government influence through regulation, and the private versus public sector of care. I know in our State that there will be a substantial curtailment of access to long-term care services for the indigent if recent trends continue.

Our neighboring State of New Jersey is already experiencing problems in insuring access to the long-term care programs for the indigent. The excellent GAO study commissioned by the House of Representatives on medicaid and nursing home care in October 1983 describes these State trends and resulting problems of medicaid patients waiting in higher-cost hospitals for nursing home beds in some detail.

To return to an example of the legal obligation of counties as it may pertain to hospital care, I can cite a circumstance which occurred last year in Mobile County, Ala. The University General Hospital finally agreed to reopen its emergency room doors because the county guaranteed to supplement the $2.3 million it already pays to the hospital for indigent care, under contract, resulting from the university's takeover of the former county facility. Officials stated that the 16.1 percent unemployment rate forced the hospital to spend $20 million in indigent care during 1982.

Increasingly this hospital is seeing noninsured patients referred by other hospitals or doctors. The county will continually be asked to commit local tax revenues for their care.

If, as portrayed in the recent GAO study, acquisitions and mergers have the effect of increasing medicare and medicaid costs, the Federal Government will likely move, as it has moved in the past, to cut those increases. The direct result of any relative reduction in Federal funding is a clear and adverse effect on local government and the public health facilities which they must operate. The medicare and medicaid programs are their financial lifeline.

Cutbacks in these programs affect the public health system in three major areas: One, access to care; two, the access to capital; and, three, inclination for proprietaries to shift assistance patients and costs to the local public sector.

Since 1981, the administration and Congress have pursued and achieved major cost controls in the Federal health care programs. Although there is a definite need for truly effective cost containment, a primary side effect of the present policies has been one of cost shifting.

As providers of last resort, counties are seeing greater and greater numbers of uninsured poor children, elderly, and unemployed in need of care. Counties are attempting to fill the gap where they can, but it is obvious that local revenues cannot do it all.

Compounding the problem is the fact that States have largely shifted the impact of Federal limits and controls to the local level. While this contains costs to the States, the overall effect is an additional county and city burden.

In long-term care some private nursing homes have simply dropped out of the medicaid program, claiming that reimbursement rates are too low for them to continue to provide care to this group of clients. This is despite the fact that Federal and State funds allowed many of these homes to be constructed in the first place.

This trend, along with numerous moratoriums on new long-term care beds by States, is creating serious problems regarding access to care. Alternatives to nursing home care, although widely discussed, exist primarily in the form of limited local demonstration sites and have not proved their cost efficiency.

The problem is further magnified by recent limits and controls on hospital reimbursement under medicare. Once again, medicare prospective payment was represented as a cost containment device. In fact, it will help to curb some costly practices which occurred under the former system of hospital reimbursement.

Yet an unfortunate side effect of the DRG program system already found is that the elderly medicare clients are being discharged from hospitals sooner and sicker. Where do these elderly,

predominantly women over the age of 80, go if there are a limited number of medicaid nursing home beds and medicare benefits have run out? It is clear that again counties will be left with a new financial, legal, and service burden.

The public hospitals and health care facilities, our Nation's form of de facto national health insurance, are also experiencing a serious lack of access to capital. Since they are financially dependent upon medicare and medicaid, and these program dollars are extremely unstable sources of revenue, such facilities must struggle with commonly low bond ratings.

Deteriorating physical plants and inability to modernize makes them vulnerable to competition from modern, high technology oriented proprietary facilities. Closure of older public facilities without public alternatives will create further access problems for the indigent.

It is not likely that proprietary hospitals located in an affluent suburban market will treat those from a depressed market area who often cannot pay for care. The same can be said for proprietary nursing home chains who have no traditional ties to the citizens of a specific community or metropolitan area.

Counties will be financially liable for the care of their indigent. Counties will be forced to pay a high premium to the profit sector to attract care resources for indigent clients.

In conclusion, NACo recognizes and supports this Nation as a pluralistic society. We believe in a balance of competition and regulation in health care and the proprietary sector has contributed to the health care needs of this country.

We would only caution that there should be a balance and that as the changes take place in the health care financing and delivery system we, as elected officials, not forget those unable to afford health care and who will pay the bill.

I would like to thank you for this opportunity of appearing before this committee. I would be pleased to answer any questions at this time.

[The prepared statement follows:]

STATEMENT OF DAVID BAUSCH, COUNTY EXECUTIVE, LEHIGH COUNTY, PENNSYLVANIA, ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES (NACo)*

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, I AM DAVID BAUSCH, COUNTY EXECUTIVE OF LEHIGH COUNTY, PENNSYLVANIA. I AM HERE TODAY ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES (NACo).*

I AM THE VICE CHAIRMAN OF NACo'S HEALTH AND EDUCATION STEERING COMMITTEE AND A MEMBER OF THE NACo BOARD OF DIRECTORS. FOR THE PAST EIGHT YEARS AS AN ELECTED OFFICIAL OF LEHIGH COUNTY, SIX OF THOSE YEARS UNDER OUR NEW FORM OF HOME RULE COUNTY GOVERNMENT, I HAVE BEEN DIRECTLY INVOLVED IN EVENTS WHICH HAVE SHAPED HEALTH CARE IN OUR COUNTY OF OVER 250,000 CITIZENS. THIS EXPERIENCE HAS AUGMENTED MY PREVIOUS BACKGROUND OF 13 YEARS IN HEALTH CARE ADMINISTRATION, WHERE I HAVE SERVED AS BOTH A HOSPITAL ADMINISTRATOR AND A COUNTY NURSING HOME ADMINISTRATOR. I ALSO HOLD A MASTER'S DEGREE IN HEALTH CARE ADMINISTRATION FROM THE UNIVERSITY OF PITTSBURGH.

I AM HERE TO SPEAK TO YOU TODAY ON THE ROLE OF OUR NATION'S COUNTIES IN HEALTH CARE, AND HOW THIS ROLE MAY BE SERIOUSLY IMPACTED BY THE RECENT RAPID GROWTH OF PROPRIETARY HOSPITALS, NURSING HOMES AND INVESTOR OWNED HEALTH CARE CHAINS. THE BURGEONING GROWTH OF FOR-PROFIT FACILITIES REPRESENTS A SIGNIFICANT NEW DIRECTION IN HEALTH CARE IN THE UNITED STATES AND IS A PUBLIC POLICY ISSUE WORTHY OF OBJECTIVE STUDY AND ANALYSIS. NACo COMMENDS THIS COMMITTEE FOR TAKING THE LEAD BY HOLDING HEARINGS ON THIS MOST IMPORTANT ISSUE.

*NACo IS THE ONLY NATIONAL ORGANIZATION REPRESENTING COUNTY GOVERNMENT IN AMERICA. ITS MEMBERSHIP INCLUDES URBAN, SUBURBAN AND RURAL COUNTIES JOINED TOGETHER FOR THE COMMON PURPOSE OF STRENGTHENING COUNTY GOVERNMENT TO MEET THE NEEDS OF ALL AMERICANS. BY VIRTUE OF A COUNTY'S MEMBERSHIP, ALL ITS ELECTED AND APPOINTED OFFICIALS BECOME PARTICIPANTS IN AN ORGANIZATION DEDICATED TO THE FOLLOWING GOALS: IMPROVING COUNTY GOVERNMENT; ACTING AS A LIAISON BETWEEN THE NATION'S COUNTIES AND OTHER LEVELS OF GOVERNMENT; AND ACHIEVING THE PUBLIC UNDERSTANDING OF THE ROLE OF COUNTIES IN THE FEDERAL SYSTEM.

WE THANK YOU FOR THE OPPORTUNITY TO PRESENT OUR VIEWS BEFORE YOU TODAY.

CENTRAL TO ANY DEBATE ABOUT THE IMPACT OF MERGERS AND ACQUISITIONS AMONG THE PROPRIETARY SECTOR ON HEALTH CARE COSTS IS THE ISSUE OF HOW THIS TREND AFFECTS THE PUBLIC HEALTH SYSTEM. IN LIGHT OF A GROWING INDIGENT POPULATION (THE ELDERLY, CHILDREN AND UNEMPLOYED), IT IS MOST IMPORTANT FOR PUBLIC OFFICIALS AT ALL LEVELS OF GOVERNMENT TO ACTIVELY ENSURE THAT THE HEALTH NEEDS OF THIS POPULATION WILL CONTINUE TO BE MET. A NEW EMPHASIS ON REIMBURSEMENT ANALYSIS AND AN INCREASING SHIFT OF NON-PROFITABLE SERVICES FROM THE FOR-PROFIT SECTOR TO THE PUBLIC SECTOR HAS SERIOUS IMPLICATIONS. THESE INCLUDE:

1. LEGAL IMPLICATIONS FOR ACCESS AND QUALITY OF CARE FOR ALL AMERICANS, DUE TO FINANCIAL PROBLEMS OR SELL OUTS OF PUBLIC PROVIDERS.
2. FINANCIAL IMPLICATIONS FOR COUNTIES AND OTHER LOCAL PUBLIC PROVIDERS, DUE TO LIMITED REVENUE/REIMBURSEMENT AND A LACK OF ACCESS TO CAPITAL FOR REPLACEMENT AND IMPROVEMENT OF FACILITIES.

<u>RECOMMENDATIONS</u>:

THE ISSUES I WILL SPEAK ABOUT TODAY ON BEHALF OF THE MEMBERSHIP OF NACo SHOW THE NEED FOR SEVERAL COORDINATED NON-PARTISAN ACTIONS IF WE WISH OUR NATION'S PUBLIC HEALTH SYSTEM TO SURVIVE. NACo PRESENTS THESE PROPOSED ACTIONS IN THE FORM OF SEVERAL STRONG RECOMMENDATIONS.

1. THE FIRST AND MOST IMPORTANT RECOMMENDATION MUST BE A SERIOUS FEDERAL COMMITMENT TO THE PROVISION OF PUBLIC HEALTH CARE IN THIS COUNTRY. VITAL TO THIS COMMITMENT MUST BE:

A. NO FURTHER REDUCTIONS OF FINANCIAL SUPPORT TO PRESENT PUBLIC HEALTH CARE PROGRAMS.

B. A FEDERAL FINANCING OF INDIGENT CARE PROGRAMS; SPECIFIC NEEDS INCLUDE A RE-THINKING AND RE-VITALIZATION OF MEDICAID; MEDICARE AUTHORIZATION TO PROVIDE FOR ALTERNATIVE FORMS OF LONG TERM CARE SUCH AS HOMEMAKER CARE; HEALTH INSURANCE FOR THE UNEMPLOYED; CHARITY CARE POOLS; AND/OR GRANT PROGRAMS FOR PUBLIC HOSPITALS.

2. REGULATION OF THE FOR-PROFIT SECTOR WHERE PRACTICES INFRINGE ON THE PUBLIC TRUST. THIS MUST INCLUDE:

A. ENFORCEMENT OF "NO DUMPING" PROVISIONS IN CURRENT LAW TO ENSURE THAT PROPRIETARY HOSPITALS AND HEALTH CARE FACILITIES TREAT THE INDIGENT AND NEEDY WHO COME TO THEIR DOORS.

B. REFINEMENT OF FEDERAL REGULATIONS WHERE CERTAIN PROVISIONS REWARD PROVIDERS WITHOUT SPECIFIC COMMITMENTS TO PUBLIC CARE. (ONE EXAMPLE IS CAPITAL PASSTHROUGHS PRESENTLY ALLOWED UNDER MEDICARE; SUCH PASSTHROUGHS OF CAPITAL COSTS MAY ENHANCE THE MARKETING OF A FACILITY WITHOUT ENSURING QUANTITY OR QUALITY OF CARE TO MEDICARE CLIENTS.)

3. A SINCERE EFFORT TO CONTAIN COSTS, WITHOUT COST SHIFTING TO LOCAL LEVEL PUBLIC CARE. THIS SHOULD INCLUDE:

A. TECHNICAL ASSISTANCE AND FUNDING TO COUNTIES TO DEVELOP OR PARTICIPATE IN:

1. PREPAID AREA-WIDE HEALTH PLANS.

2. HOME HEALTH SERVICES AND OTHER ALTERNATIVES TO INSTITUTIONAL CARE FOR THOSE NOT NEEDING INSTITUTIONAL CARE.

I CAN COMMENT THAT MANY COUNTIES, INCLUDING MY OWN, ARE PURSUING SUCH ALTERNATIVES NOW. ASSISTANCE RATHER THAN FUNDING REDUCTIONS WOULD MOVE COUNTIES AND THE ENTIRE HEALTH CARE DELIVERY SYSTEM TOWARD THESE IMPORTANT CHANGES FOR THE FUTURE.

4. A FEDERAL COMMITMENT TO ASSIST PUBLIC HOSPITALS TO OBTAIN ACCESS TO CAPITAL. THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS HAS MADE SEVERAL RECOMMENDATIONS INCLUDING CREDIT ENHANCEMENTS, DIRECT GRANTS TO PUBLIC HOSPITALS AND GREATER FLEXIBILITY IN THE TAX CODE. THESE COMMENTS CAN BE MADE AVAILABLE TO YOU UPON REQUEST.

COUNTY ROLE:

IT IS AN ACCEPTED FACT THAT COUNTIES PLAY AN IMPORTANT PART IN OUR PUBLIC HEALTH CARE SYSTEM. AS PROVIDERS, FINANCERS, PLANNERS AND PURCHASERS OF HEALTH SERVICES, COUNTIES IN ONE WAY OR ANOTHER HAVE A ROLE IN ADDRESSING THE HEALTH CARE NEEDS OF VIRTUALLY ALL AMERICANS.

COLLECTIVELY, COUNTIES ALSO HAVE A SPECIAL ROLE NATIONWIDE IN SERVING TO MEET THE HEALTH NEEDS OF INDIGENT CITIZENS. IN THE MAJORITY OF STATES, COUNTIES ARE LEGALLY RESPONSIBLE FOR INDIGENT HEALTH CARE OR ALL UNREIMBURSED HEALTH CARE COSTS. DUE TO THE RAPIDLY RISING COST OF HEALTH CARE GOODS AND SERVICES, AND COST CONTAINMENT MEASURES IN PUBLIC ASSISTANCE AND PUBLIC HEALTH PROGRAMS BY THE FEDERAL GOVERNMENT AND MOST STATES, OVERALL HEALTH CARE EXPENDITURES BY COUNTIES

ARE ON THE INCREASE.

OF THE 1900 PUBLIC HOSPITALS IN THIS COUNTRY, OVER 900 ARE DIRECTLY AFFILIATED WITH COUNTY GOVERNMENT. PUBLIC HOSPITALS PROVIDE A HEALTH "SAFETY NET" FOR THE ELDERLY POOR WHO HAVE UNMET NEEDS, CHILDREN OF THE WORKING AND NON-WORKING POOR, AND THE "NEW POOR" AMONG THE UNEMPLOYED WHO HAVE LOST THEIR HEALTH BENEFITS, BUT WHO DO NOT QUALIFY FOR MEDICAID OR OTHER FORMS OF ASSISTANCE. COUNTIES ALSO OWN AND OPERATE OVER 600 NURSING HOMES, AND CARRY OUT THE MULTIPLE RESPONSIBILITIES THAT CONTRIBUTE TO THE LONG TERM HEALTH CARE NEEDS OF OUR NATION'S GROWING ELDERLY POPULATION, INCLUDING MEDICAID, THE OLDER AMERICAN'S ACT PROGRAMS, HOME HEALTH CARE AND TITLE XX SERVICES.

OVER 2,000 COUNTY HEALTH DEPARTMENTS OPERATE, FUND, AND PROVIDE BASIC PUBLIC HEALTH SERVICES, FROM RODENT CONTROL, FLUORIDATION, AND EMERGENCY MEDICAL SERVICES TO MATERNAL AND CHILD PRIMARY HEALTH CARE AND RAPE PREVENTION.

LOCAL REVENUES SUPPORT THE PROVISION OF COUNTY HEALTH SERVICES FOR MILLIONS OF AMERICANS WHO HAVE NO HEALTH COVERAGE. IN 1982, COUNTIES SPENT OVER 22 BILLION DOLLARS ON HEALTH CARE. THE LARGEST PUBLIC HOSPITALS PROVIDED CLOSE TO A BILLION DOLLARS IN NON-MEDICAID CHARITY CARE IN 1980 AND ABOUT 25 PERCENT OF THESE LARGE PUBLIC HOSPITALS ARE COUNTY-OWNED.

COUNTY PUBLIC HEALTH FACILITIES IN TROUBLE:

THE NEXT SEVERAL YEARS MAY WELL DETERMINE IF EQUAL ACCESS TO HEALTH CARE FOR ALL CITIZENS IS POSSIBLE OR IF A PERSON'S INDIVIDUAL ASSETS WILL BECOME THE CRITERIA FOR ADEQUATE HEALTH CARE ACCESS. NACo BELIEVES THAT WE HAVE REASON FOR GREAT CONCERN, SINCE THERE ARE

MANY INDICATORS THAT THE VERY SURVIVAL OF OUR PUBLIC HEALTH SYSTEM IN THE UNITED STATES IS AT STAKE. WE KNOW THAT PUBLIC HOSPITAL AND NURSING HOME SALES OR CLOSURES ARE ON THE INCREASE. IN FACT, A RECENT EXAMPLE OF GROWING FINANCIAL PROBLEMS FOR THE PUBLIC HOSPITALS IN NORTH CAROLINA, AND INCREASED INTEREST BY PROPRIETARY HEALTH CARE CHAINS TO PURCHASE THESE HOSPITALS, PROMPTED THE 1983 STATE GENERAL ASSEMBLY TO TEMPORARILY STOP THE SALE OF COUNTY AND CITY HOSPITALS TO COMPANIES OWNED BY INVESTORS.

WAYNE COUNTY, MICHIGAN; CUYAHOGA COUNTY, OHIO; AND POLK COUNTY, IOWA ARE BUT A FEW OF THE MANY COUNTIES STRUGGLING TO KEEP THEIR HOSPITAL DOORS OPEN. ALL THREE JURISDICTIONS ARE DENSELY POPULATED, HAVE HIGH UNEMPLOYMENT AND SUBSEQUENTLY REPRESENT MANY UNINSURED PEOPLE WHOSE HEALTH CARE THEY MUST ASSIST IN PAYING FOR.

MAY I BRIEFLY DESCRIBE OTHER SIMILAR EXAMPLES OF THE PUBLIC HEALTH CRISIS IN COUNTIES ACROSS THE COUNTRY.

IN 1983, HENNEPIN COUNTY, MINNESOTA DETERMINED THAT THEIR MEDICALLY INDIGENT POPULATION -- THOSE WHO DON'T QUALIFY FOR MEDICAID, BUT HAVE NO HEALTH INSURANCE -- HAS INCREASED AND IS CONTINUING TO CLIMB. THESE PEOPLE RECEIVE SOME MEDICAL CARE THROUGH COUNTY GENERAL ASSISTANCE, SUPPORTED BY LOCAL TAXES, AND SOME STATE DOLLARS. OTHER COUNTY STATISTICS POINT TO SHARP INCREASES IN ELIGIBLE 18-21 YEAR OLDS IN THE FEDERALLY FUNDED "MEDICAL ASSISTANCE ONLY" CHILDREN'S PROGRAM. THE COUNTY SUSPECTS THIS SHARP INCREASE IS DUE TO HIGH UNEMPLOYMENT. THE COUNTY ALSO COMPLETED A SURVEY LAST YEAR OF THE EFFECT OF FEDERAL/STATE LIMITS UPON REIMBURSEMENT WHERE PEOPLE HAVE LOST THEIR COMPREHENSIVE HEALTH COVERAGE. THEY FOUND THAT OVER THIRTY PERCENT OF THE RESPONDENTS STATED THAT THEY WERE DEFERRING ALL MEDICAL CARE.

IN TEXAS, WHERE UNEMPLOYMENT REACHED 10.5 PERCENT LAST YEAR, HARRIS COUNTY SAW A 12 PERCENT INCREASE IN INDIGENT OUTPATIENT CARE. COUNTY OFFICIALS ESTIMATED THAT AT LEAST TWO-THIRDS OF THIS INCREASE HAS BEEN DIRECTLY RELATED TO UNEMPLOYMENT. IN 1982, OVER TWO-THIRDS OF THE COUNTY HOSPITAL'S 150 MILLION DOLLAR BUDGET WENT TO PROVIDE SOME FORM OF CHARITY CARE.

NEW YORK STATE HAS BEEN FORCED TO CLOSE OR SUBSTANTIALLY DECREASE MANY SERVICES PROVIDED AT IN-PATIENT MENTAL HEALTH FACILITIES. CHATAUQUA COUNTY NOTES THAT, AT THE SAME TIME THAT THE STRESS OF UNEMPLOYMENT HAS LED TO A RISE IN REQUESTS FOR MENTAL HEALTH SERVICES, THE COUNTY AND OTHER SERVICE PROVIDERS ARE SUDDENLY BEING INUNDATED WITH FORMER IN-PATIENTS OF STATE FACILITIES.

UNFORTUNATELY, SIMILAR EXAMPLES TO THESE DESCRIBED ABOUND IN COUNTIES ACROSS THE NATION. ECONOMIC RECOVERY WILL NOT ALONE STEM THE TIDE OF ADDITIONAL PUBLIC HEALTH CARE BURDENS.

IMPACT OF MERGERS AND ACQUISITIONS ON HEALTH CARE COSTS AND THE PUBLIC HEALTH SYSTEM:

THERE HAS BEEN A TREND IN RECENT YEARS TO SPEAK OF A HEALTH CARE MARKETPLACE AND BENEFICIAL COMPETITION BETWEEN HEALTH CARE PROVIDERS AS A WAY TO HOLD DOWN COSTS. WHILE THERE ARE SOME OBVIOUS BENEFITS TO THE HEALTH CARE CONSUMER OF HAVING CHOICES IN HEALTH CARE, IT IS ALSO IMPORTANT TO RECOGNIZE THAT OUR NATIONAL HEALTH PROGRAMS, MEDICARE AND MEDICAID AMONG THEM, HAVE CREATED STRONG INCENTIVES AND DISINCENTIVES THAT INFLUENCE THE MARKETPLACE. AS A RESULT, SOME PATIENTS AND SOME ILLNESSES ARE GENERALLY LESS DESIREABLE CHOICES IN THE FOR-PROFIT SECTOR. THEY ARE SIMPLY NOT "PROFITABLE", AND THE WISE BUSINESSMAN WOULD PREFER TO MARKET BEDS, CARE AND BILLING TO OTHER CLIENTS.

THE PUBLIC HEALTH SECTOR ON THE OTHER HAND DOES NOT HAVE AN ENTREPRENEURIAL CHOICE. BY MORAL, SOCIAL, POLITICAL, AND LEGAL OBLIGATION OUR COUNTIES, AS PUBLIC HEALTH PROVIDERS, WILLINGLY SHOULDER THIS BURDEN. THIS HAS BEEN A PRACTICE LONG ACCEPTED, AND FEW WOULD ARGUE THE NEED FOR COUNTIES AND OTHER PUBLIC PROVIDERS TO GIVE THIS CARE.

I MUST NOTE BEFORE CONTINUING THAT I AM NOT ARGUING AGAINST THE NEED FOR EFFICIENT PROVISION OF HEALTH CARE SERVICES IN BOTH THE PUBLIC AND PRIVATE SECTOR. THE QUESTIONS WE ARE ADDRESSING TODAY HAVE MORE TO DO WITH NATIONAL ETHICS AND FISCAL REALITY THAN COST EFFICIENCY. STUDIES ARE NOW SHOWING THAT IT IS NOT UNUSUAL FOR INVESTOR OWNED HOSPITALS TO CHARGE MORE THAN A PUBLIC HOSPITAL FOR SIMILAR SERVICES. OF MORE CONCERN ARE CERTAIN SPECIFIC INSTANCES OF AN ACTIVE AVOIDANCE OF ADMISSIONS FOR INDIGENT OR OTHERWISE UNPROFITABLE PATIENTS. NACo HAS COPIES OF TWO MAPS PURPORTEDLY USED BY PROPRIETARY HOSPITALS TO SEND UNDESIRED PATIENTS TO COUNTY FACILITIES. A QUESTION WE MUST ASK IS WHERE WILL THESE PATIENTS BE SENT IF THESE PUBLIC HEALTH FACILITIES ARE SOLD OR ARE CLOSED?

TO FURTHER DISCUSS COST EFFICIENCY IN CONTRAST TO BUSINESS EFFICIENCY, A STUDY BY BLUE SHIELD OF NORTH CAROLINA HAS SHOWN THAT PROPRIETARY CLAIMS FOR THREE ROUTINE SURGERIES WERE 20 PERCENT HIGHER THAN PUBLIC HOSPITAL CLAIMS. THIS STUDY PRECIPITATED THE RECENT ACTION BY THE GENERAL ASSEMBLY TO PLACE A MORATORIUM ON THE SALE OF COUNTY AND CITY PUBLIC HOSPITALS MENTIONED EARLIER. NACo HAS ATTACHED COPIES OF THE STUDY FOR THE RECORD.

IN ADDITION, A STUDY OF CALIFORNIA HOSPITALS RECENTLY PUBLISHED IN THE NEW ENGLAND JOURNAL OF MEDICINE CONCLUDED THAT FOR-PROFIT

HOSPITALS WERE NOT MORE EFFICIENT, ACTUALLY COST MORE, AND REFRAINED, WHEN POSSIBLE, FROM TREATING INDIGENT, UNINSURED PATIENTS.

1. LEGAL IMPLICATIONS FOR COUNTIES

NACo HAS CONDUCTED A SURVEY OF STATE ATTORNEYS GENERAL NATIONWIDE WHICH ASKED FOR A REVIEW OF THE ULTIMATE LEGAL RESPONSIBILITY WITHIN EACH STATE FOR UNREIMBURSED, INDIGENT PATIENT CARE COSTS. WE HAVE RECEIVED RESPONSES FROM OVER HALF OF THE STATES SURVEYED. OF THOSE, THE MAJORITY OF STATES HAVE LAWS WHICH HOLD COUNTIES LIABLE FOR UNREIMBURSED HEALTH CARE COSTS.

WHERE COUNTIES ARE LEGALLY LIABLE FOR INDIGENT CARE, THE LOSS OF CONTROL OVER THE PROVIDER (HOSPITAL OR NURSING HOME) POSES A SERIOUS POTENTIAL THREAT TO ACCESS TO HEALTH CARE. WHILE COUNTIES ARE MORE INCLINED TO SELL OR CLOSE FACILITIES DUE TO CUTBACKS IN FEDERAL OR STATE FUNDING ASSISTANCE, THOSE VERY CUTBACKS WILL ULTIMATELY IMPEDE COUNTIES' ABILITY TO MEET INDIGENT CARE COSTS IN ALTERNATIVE PRIVATE SETTINGS. I MIGHT ADD THAT NEW LIMITS IN MEDICARE AND MEDICAID VERSUS A STEADILY INCREASING POPULATION OF AT RISK ELDERLY WILL EXACERBATE THIS SITUATION FURTHER IN MOST COUNTIES.

I CAN MENTION SOME RECENT DEVELOPMENTS IN MY HOME STATE OF PENNSYLVANIA AS A DETAILED EXAMPLE. PENNSYLVANIA COUNTIES HAVE TRADITIONALLY PLAYED A MAJOR ROLE BOTH LEGALLY AND CONCEPTUALLY IN PUBLIC NURSING HOME CARE. FORTY-FOUR OF 67 COUNTIES PRESENTLY PROVIDE SOME FORM OF PUBLIC NURSING HOME SERVICES. ALTHOUGH COUNTY HOMES ARE ONLY THE THIRD MAJOR

PROVIDER OF LONG TERM CARE BEDS IN OUR STATE, BEHIND PROPRIETARY AND NON-PROFIT FACILITIES, COUNTY HOMES ARE THE NUMBER ONE PROVIDER OF MEDICAID LONG TERM CARE BEDS. FULLY 91 PERCENT OF ALL BED DAYS IN THESE COUNTY FACILITIES ARE PROVIDED TO MEDICAID PATIENTS. ADMISSION INFORMATION SHOWS THAT COUNTIES ACCEPT PRIMARILY THE LONG STAY, NON-DISCHARGEABLE PATIENT WITH MULTIPLE HEALTH PROBLEMS. THIS PATIENT ALSO HAS VERY LIMITED FINANCIAL ASSETS BY THE TIME HE OR SHE COMES TO OUR FACILITIES.

SOME RECENT TRENDS ARE QUITE DISTURBING. IN PART DUE TO A RECENT REDEFINITION OF CARE STATEWIDE, TWO COUNTIES HAVE OPTED OUT OF THE SKILLED NURSING CARE PROGRAM IN THE LAST YEAR AND A THIRD COUNTY IS CONTEMPLATING DOING THE SAME. ONE COUNTY HAS SIMPLY CLOSED DOWN BEDS IN ALL LEVELS OF CARE. IN THE PAST FIVE YEARS ALMOST ONE QUARTER OF THE COUNTIES HAVE CONVERTED TO MANAGEMENT CONTRACT OPERATION THROUGH PROPRIETARY FIRMS. ANOTHER RECENT TREND IS TO "FARM OUT" COUNTY HOME ANCILLARY SERVICES SUCH AS PHYSICIAN CONTRACTS, PHYSICAL THERAPY, PHARMACY, LABORATORY AND CLINIC SERVICES, AND MEDICAL SUPPLY SERVICES TO PRIVATE VENDORS. THESE VENDORS DIRECTLY BILL MEDICARE FOR REIMBURSEMENT. NORMALLY THIS REIMBURSEMENT IS HIGHER THAN THE COUNTY HOME WOULD RECEIVE IF THEY PROVIDED THE SERVICE WITH THEIR OWN STAFF. THIS SEPARATE BILLING, HOWEVER, IS ALSO MORE COSTLY TO MEDICARE AND ALSO TO THE CONSUMER, BUT DOES PROVIDE A FAIR PROFIT TO THE PRIVATE VENDOR.

PENNSYLVANIA COUNTY HOMES CONTINUE TO ACCEPT A HEAVY BURDEN OF TRULY INDIGENT PATIENTS IN ADDITION TO THE MEDICALLY NEEDY. THE MEDICALLY NEEDY HAVE OFTEN SPENT DOWN THEIR LIFELONG ASSETS IN A NEARBY PROPRIETARY FACILITY BEFORE DISCHARGE TO THE COUNTY HOME. OUR COMMUNITIES AND CITIZENS APPEAR TO HAVE ACCEPTED THE TACIT UNDERSTANDING THAT IN ORDER FOR PROPRIETARY FACILITIES TO MAKE A PROFIT, THEY MUST LIMIT THE NUMBER OF MEDICAID BEDS THEY PROVIDE. HOWEVER, THIS UNDERSTANDING DOES MEAN AN INCREASING BURDEN FOR COUNTY TAXPAYERS. WHEN A NEW PROPRIETARY HOME HAS OPENED IN THE PAST, THE HOME WOULD OFTEN ACCEPT A HIGH PERCENTAGE OF MEDICAID CLIENTS JUST TO INITIALLY FILL BEDS. THAT PERCENTAGE HAS DROPPED PRECIPITOUSLY ONCE PRIVATE PAY ADMISSIONS HAVE BEEN FOUND.

YOU MAY NOT BE SURPRISED TO HEAR THAT NATIONWIDE NURSING HOME CHAINS HAVE FOUND PENNSYLVANIA TO BE FERTILE GROUND FOR ACQUISITIONS. ONE CHAIN THAT RECENTLY CAME IN TO OUR STATE HAS GROWN FROM A SMALL NUMBER OF HOMES TO OVER 700 IN LESS THAN A DECADE. EVEN THE LEADER HOMES, A WELL-RUN PENNSYLVANIA CHAIN OF 21 HOMES WAS RECENTLY BOUGHT BY A LARGER NATIONWIDE PROPRIETARY CHAIN.

I HOPE THAT MY PERSONAL COMMENTS HELP TO CLARIFY THE SUBTLE, YET CONSEQUENTIAL INTERACTION BETWEEN MEDICAID AND MEDICARE FUNDING, STATE GOVERNMENT INFLUENCE THROUGH REGULATION, AND THE PRIVATE VERSUS PUBLIC SECTOR OF CARE. I KNOW IN OUR STATE THAT THERE WILL BE A SUBSTANTIAL CURTAILMENT OF ACCESS TO LONG TERM CARE SERVICES FOR THE INDIGENT IF RECENT TRENDS CONTINUE.

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OUR NEIGHBORING STATE OF NEW JERSEY IS ALREADY EXPERIENCING PROBLEMS IN ENSURING ACCESS TO THE LONG TERM CARE PROGRAMS FOR INDIGENT. THE EXCELLENT GAO STUDY COMMISSIONED BY THE HOUSE OF REPRESENTATIVES ON MEDICAID AND NURSING HOME CARE (OCTOBER 1983) DESCRIBES THESE STATE TRENDS (AND RESULTING PROBLEMS OF MEDICAID PATIENTS WAITING IN HIGHER COST HOSPITALS FOR NURSING HOME BEDS) IN SOME DETAIL.

TO RETURN TO AN EXAMPLE OF THE LEGAL OBLIGATION OF COUNTIES AS IT MAY PERTAIN TO HOSPITAL CARE, I CAN CITE A CIRCUMSTANCE WHICH OCCURRED LAST YEAR IN MOBILE COUNTY, ALABAMA. THE UNIVERSITY GENERAL HOSPITAL FINALLY AGREED TO RE-OPEN ITS EMERGENCY ROOM DOORS BECAUSE THE COUNTY GUARANTEED TO SUPPLEMENT THE 2.3 MILLION DOLLARS IT ALREADY PAYS TO THE HOSPITAL FOR INDIGENT CARE, UNDER CONTRACT, RESULTING FROM THE UNIVERSITY'S TAKEOVER OF THE FORMER COUNTY FACILITY. OFFICIALS STATED THAT THE 16.1 PERCENT UNEMPLOYMENT RATE FORCED THE HOSPITAL TO SPEND $20 MILLION IN INDIGENT CARE DURING 1982.

INCREASINGLY, THIS HOSPITAL IS SEEING NON-INSURED PATIENTS REFERRED BY OTHER HOSPITALS OR DOCTORS. THE COUNTY WILL CONTINUALLY BE ASKED TO COMMIT LOCAL TAX REVENUES FOR THEIR CARE.

2. FINANCIAL IMPLICATIONS FOR COUNTIES

IF, AS PORTRAYED IN THE RECENT GAO STUDY, ACQUISITIONS AND MERGERS HAVE THE EFFECT OF INCREASING MEDICARE AND MEDICAID COSTS, THE FEDERAL GOVERNMENT WILL LIKELY MOVE,

AS IT HAS MOVED IN THE PAST, TO CUT THOSE INCREASES. THE DIRECT RESULT OF ANY RELATIVE REDUCTION IN FEDERAL FUNDING IS A CLEAR AND ADVERSE AFFECT ON LOCAL GOVERNMENT AND THE PUBLIC HEALTH FACILITIES WHICH THEY MUST OPERATE. THE MEDICARE AND MEDICAID PROGRAMS ARE THEIR FINANCIAL LIFELINE.

CUTBACKS IN THESE PROGRAMS AFFECT THE PUBLIC HEALTH SYSTEM IN THREE MAJOR AREAS:

1. ACCESS TO CARE;
2. ACCESS TO CAPITAL;
3. INCLINATION FOR PROPRIETARIES TO SHIFT ASSISTANCE CLIENTS AND COSTS TO THE LOCAL PUBLIC SECTOR.

SINCE 1981, THE ADMINISTRATION AND CONGRESS HAVE PURSUED AND ACHIEVED MAJOR COST CONTROLS IN THE FEDERAL HEALTH CARE PROGRAMS. ALTHOUGH THERE IS A DEFINITE NEED FOR TRULY EFFECTIVE COST CONTAINMENT, A PRIMARY SIDE EFFECT OF THE PRESENT POLICIES HAS BEEN ONE OF COST SHIFTING. AS PROVIDERS OF LAST RESORT, COUNTIES ARE SEEING GREATER AND GREATER NUMBERS OF UNINSURED POOR CHILDREN, ELDERLY AND UNEMPLOYED IN NEED OF CARE. COUNTIES ARE ATTEMPTING TO FILL THE GAP WHERE THEY CAN, BUT IT IS OBVIOUS THAT LOCAL REVENUES CANNOT DO IT ALL. COMPOUNDING THE PROBLEM IS THE FACT THAT STATES HAVE LARGELY SHIFTED THE IMPACT OF FEDERAL LIMITS AND CONTROLS TO THE LOCAL LEVEL. WHILE THIS "CONTAINS COSTS" TO THE STATES, THE OVERALL EFFECT IS AN ADDITIONAL COUNTY AND CITY BURDEN. IN LONG TERM CARE, SOME PRIVATE NURSING HOMES HAVE SIMPLY DROPPED OUT OF THE MEDICAID PROGRAM, CLAIMING THAT REIMBURSEMENT RATES ARE TOO LOW FOR THEM TO CONTINUE

TO PROVIDE CARE TO THIS GROUP OF CLIENTS. THIS IS DESPITE THE FACT THAT FEDERAL AND STATE FUNDS ALLOWED MANY OF THESE HOMES TO BE CONSTRUCTED IN THE FIRST PLACE.

THIS TREND, ALONG WITH NUMEROUS MORATORIUMS ON NEW LONG TERM CARE BEDS BY STATES, IS CREATING SERIOUS PROBLEMS REGARDING ACCESS TO CARE. ALTERNATIVES TO NURSING HOME CARE, ALTHOUGH WIDELY DISCUSSED, EXIST PRIMARILY IN THE FORM OF LIMITED LOCAL DEMONSTRATION SITES, AND HAVE NOT PROVED THEIR COST EFFICIENCY.

THE PROBELM IS FURTHER MAGNIFIED BY RECENT LIMITS AND CONTROLS ON HOSPITAL REIMBURSEMENT UNDER MEDICARE. ONCE AGAIN, MEDICARE PROSPECTIVE PAYMENT WAS REPRESENTED AS A COST CONTAINMENT DEVICE. IN FACT, IT WILL HELP TO CURB SOME COSTLY PRACTICES WHICH OCCURRED UNDER THE FORMER SYSTEM OF HOSPITAL REIMBURSEMENT. YET AN UNFORTUNATE SIDE EFFECT OF THE DRG SYSTEM ALREADY FOUND IS THAT ELDERLY MEDICARE CLIENTS ARE BEING DISCHARGED FROM HOSPITALS SOONER AND SICKER. WHERE DO THESE ELDERLY, PREDOMINANTLY WOMEN OVER AGE 80 GO IF THERE ARE A LIMITED NUMBER OF MEDICAID NURSING HOME BEDS AND MEDICARE BENEFITS HAVE RUN OUT? IT IS CLEAR THAT, AGAIN, COUNTIES WILL BE LEFT WITH A NEW FINANCIAL, LEGAL AND SERVICE BURDEN.

THE PUBLIC HOSPITALS AND HEALTH CARE FACILITIES, OUR NATION'S FORM OF "DE FACTO" NATIONAL HEALTH INSURANCE, ARE ALSO EXPERIENCING A SERIOUS LACK OF ACCESS TO CAPITAL. SINCE THEY ARE FINANCIALLY DEPENDENT ON MEDICARE AND MEDICAID, AND THESE PROGRAM DOLLARS ARE EXTREMELY UNSTABLE

SOURCES OF REVENUE, SUCH FACILITIES MUST STRUGGLE WITH COMMONLY LOW BOND RATINGS. DETERIORATING PHYSICAL PLANTS AND INABILITY TO MODERNIZE MAKES THEM VULNERABLE TO COMPETITION FROM MODERN, HIGH TECHNOLOGY ORIENTED PROPRIETARY FACILITIES. CLOSURE OF OLDER PUBLIC FACILITIES, WITHOUT PUBLIC ALTERNATIVES WILL CREATE FURTHER ACCESS PROBLEMS FOR THE INDIGENT.

IT IS NOT LIKELY THAT PROPRIETARY HOSPITALS LOCATED IN AN AFFLUENT SUBURBAN MARKET WILL TREAT THOSE FROM A DEPRESSED MARKET AREA WHO OFTEN CANNOT PAY FOR CARE. THE SAME CAN BE SAID FOR PROPRIETARY NURSING HOME CHAINS WHO HAVE NO TRADITIONAL TIES TO THE CITIZENS OF A SPECIFIC COMMUNITY OR METROPOLITAN AREA. COUNTIES WILL BE FINANCIALLY LIABLE FOR THE CARE OF THEIR INDIGENT. COUNTIES WILL BE FORCED TO PAY A HIGH PREMIUM TO THE PROFIT SECTOR TO ATTRACT CARE RESOURCES FOR INDIGENT CLIENTS.

CONCLUSION:

IN CONCLUSION, NACo RECOGNIZES AND SUPPORTS THIS NATION AS A PLURALISTIC SOCIETY. WE BELIEVE IN A BALANCE OF COMPETITION AND REGULATION IN HEALTH CARE AND THE PROPRIETARY SECTOR HAS CONTRIBUTED TO THE HEALTH CARE NEEDS OF THIS COUNTRY.

WE WOULD ONLY CAUTION THAT THERE SHOULD BE A BALANCE, AND THAT, AS THE CHANGES TAKE PLACE IN THE HEALTH CARE FINANCING AND DELIVERY SYSTEM, WE, AS ELECTED OFFICIALS, NOT FORGET THOSE UNABLE TO AFFORD HEALTH CARE, AND WHO WILL PAY THE BILL. I WOULD LIKE TO THANK YOU FOR THE OPPORTUNITY OF APPEARING BEFORE THIS COMMITTEE. I WOULD BE PLEASED TO ANSWER ANY QUESTIONS AT THIS TIME.

DIRECTIONS FROM SANTA MONICA HOSPITAL EMERGENCY ROOM

TO: HARBOR GENERAL HOSPITAL IN TORRANCE, CALIF.

BY CAR: SANTA MONICA FWY EAST

TO

SAN DIEGO FWY SOUTH

TO

[redacted]

TO

HARBOR FWY SOUTH

EXIT FROM HARBOR FWY AT CARSON AVE. TURN RIGHT

HARBOR GENERAL HOSPITAL
1000 W. CARSON AVE.
TORRANCE, CALIF. 213) 533-3533

BY BUS: (16th ST AND WILSHIRE BLVD. SANTA MONICA) VIA RTD BUS AND TORRANCE BUS.
INFORMATION 626-4455

ASK FOR TRANSFER WHEN BOARDING BUS LINE.
RTD #20 OR #308 EAST ON WILSHIRE BLVD. TO DOWNTOWN LOS ANGELES.
EXIT BUS AT 7TH AND HILL.
WALK SOUTH 2 BLOCKS TO 9TH ST.
ON 9TH ST. BETWEEN HILL AND BROADWAY - TAKE THE #1 TORRANCE BUS LINE EXPRESS
THE TORRANCE BUS LINE #1 HAS EXPRESS SERVICE ALL THE WAY TO HARBOR GENERAL.

APPROXIMATE BUS FARE FOR THE ENTIRE TRIP. $1.10.
" TRAVEL TIME 2¼ HOURS.

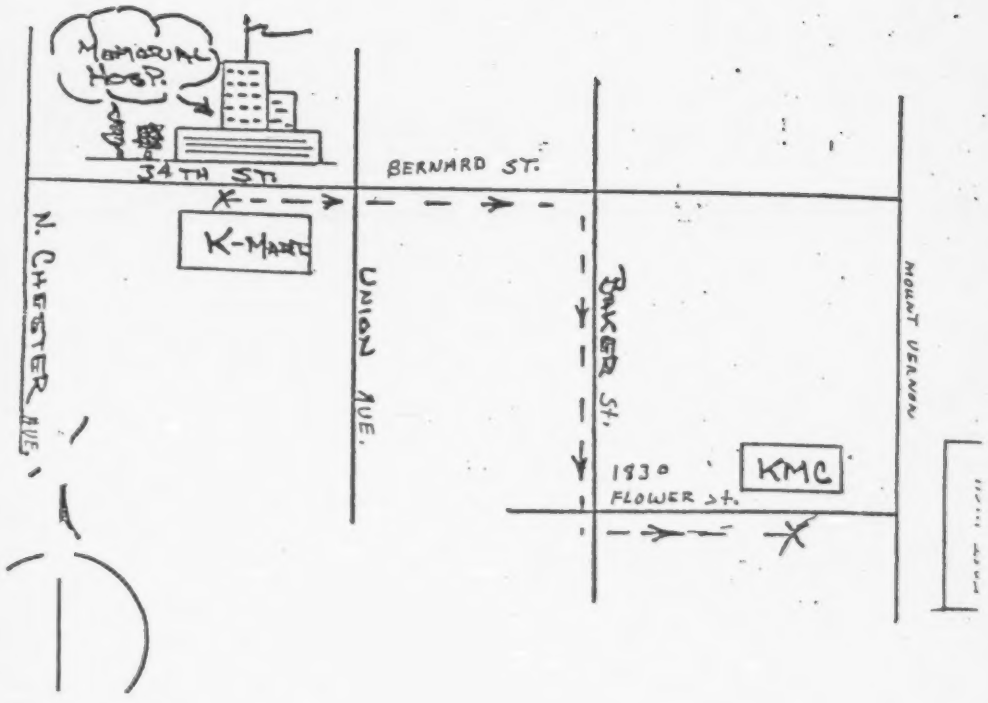
OR
ASK FOR TRANSFER WHEN BOARDING BUS LINE

RTD #20 OR #308 EAST ON WILSHIRE BLVD. TO WESTWOOD BLVD.
EXIT ON WESTWOOD. TAKE THE #88 SOUTH ON WESTWOOD TO THE LAX TERMINAL
EXIT AT 98TH ST. & VICKSBURG ( LAX TERMINAL - LOS ANGELES AIRPORT)
TAKE #232 BUS FROM LAX TO PACIFIC COAST HIGHWAY AND TORRANCE BLVD.
EXIT AT PCH AND TORRANCE BLVD.
TAKE #3 TORRANCE BUS EAST ON TORRANCE BLVD. TO HARBOR GENERAL HOSPITAL
1000 W. CARSON BLVD.
TORRANCE CA. 213) 533-3533

APPROXIMATE BUS FARE FOR THE ENTIRE TRIP. $1.00.
" TRAVEL TIM 2¼ HOURS.

RTD BUS FARE IS 50¢. ALWAYS ASK FOR TRANSFER WHICH IS 10¢.

DATED: NOVEMBER 1982


MEMORIAL HOSP.
34TH ST.
BERNARD ST.
K-MART
N. CHESTER AVE.
UNION AVE.
BAKER ST.
1930
FLOWER ST.
KMC
MOUNT VERNON

Chairman RANGEL. Mr. Bausch, how do you relate the plight of public hospitals with the accounting question that is before us on medicare today?

Mr. BAUSCH. Basically our problem is that we see that there are homes and hospitals being sold to national chains who are being selective in the patients that they are treating, and we have some examples, as I stated.

Chairman RANGEL. But if you assume from what the witnesses that have testified indicate that these chains are going to continue these acquisitions, they are going to continue to merge, notwithstanding what changes we made in the reimbursement rate, how would these changes be of any assistance to the plight of the public hospitals that, in the final analysis, are the community doctors for the poor and the uninsured?

Mr. BAUSCH. Well, I heard the testimony from a number of people and I was somewhat confused because I heard differing opinions of what their positions were and the effect that would be incurred by the change in the medicare program.

As I see it, there has to be some moratorium on the acquisition or at least some regulation that they have a responsibility also for the indigent in our community. Many of them are eleemosynary institutions who have tax advantages who I think still have a responsibility. You have some Hill-Burton hospitals that apparently are being sold, and they have an obligation—at least that was the obligation we had, and we had Hill-Burton at one time—that they have to provide some care for the community, and that is why they were approved.

Chairman RANGEL. They never even attempted to recognize the law was in existence until a few years ago.

Mr. BAUSCH. I understand.

Chairman RANGEL. Let me say this, sir. You are an elected official and so you know better than most witnesses that the plight of the poor as it relates to hospital care is one that does not have a very strong constituency.

Mr. BAUSCH. I know it.

Chairman RANGEL. And it would seem to me that you could make some of our jobs much easier if we heard from the county executive associations or we heard from the Public Hospital Association or somebody that would make their voice heard while the Congress goes through a very difficult political decision in cutting back assistance.

Both you and I know that local and State governments have been unable or unwilling to fill the gap merely because it is just not a popular thing to do. It is easier, really, to close the hospital, which has happened far too often in many of our communities.

But I want to thank you for straining the agenda for today and bringing to us the plight of the public hospitals because I know that the Federal Government should be involved to give assistance to those States that find themselves caught in the plight which they did not create. And certainly coming from the State of New York, with all of the illegal aliens and the working poor and the uninsured, it does seem to me to be a national problem rather than one which local governments should have to bear.

Mr. BAUSCH. I think unfortunately the need is going to grow so graphically. We are talking about a doubling of the population, the elderly population, by the year 2000 and a tripling by 2035.

Chairman RANGEL. What surprises me as almost a religious man is how the religious-sponsored hospitals in these communities do not act as if they give a damn about the plight of the poor in the public hospitals. Every time we hear from the secular hospitals it seems as though they are asking us to approve the reimbursement break, and what you are talking about are patients that have no reimbursement.

Mr. BAUSCH. I think it is interesting. There has just been a State supreme court decision on a hospital where they sued the county for indigent care, and they went back 10 years and, of course, the court decided they could not go back that far, but they went back 2 years and sued the county for $370,000 for indigent care, and it happened to be a church-related institution, which is interesting.

Chairman RANGEL. Closely related, but——

Mr. BAUSCH. They also received Hill-Burton. They have an economic problem, though, too. They have bills to pay and there is a limit to where the funds come from.

Chairman RANGEL. They have taken an oath that is far more serious than the ones that you and I have taken.

Mr. Chairman?

Chairman JACOBS. No questions.

Chairman RANGEL. Thank you. Please try to hook up with the Association of Public Hospitals. I work very closely with them.

Mr. BAUSCH. If there is anything that I personally can do or NACo can do we would be glad to.

Chairman RANGEL. You were courageous to bring this up at this time. It has to be said. I think Larry Gage is the person that organizes them and they need a lot of foot soldiers because certainly you do not expect the American Hospital Association to be dealing with this problem.

So the Association of Public Hospitals is the only one out there to deal with the problem, and perhaps the county executives associations, in which I am certain you are active. It is a problem that is going to get worse.

Mr. BAUSCH. It certainly will. We do work with Mr. Gage.

Chairman RANGEL. I did have legislation introduced which would deal with economically distressed hospitals, which did not restrict itself to public hospitals. The problem is that there is no constituency supporting health care as opposed to other types of spending for the poor.

Mr. BAUSCH. I understand.

Chairman RANGEL. Thank you very much.

Our last witness is Patrice Feinstein, Associate Administrator for Policy at HCFA. You may proceed when you are ready. Your full statement will be entered into the record and we thank you for your patience.

**STATEMENT OF PATRICE HIRSCH FEINSTEIN, ASSOCIATE ADMINISTRATOR FOR POLICY, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY ROBERT STREIMER, ACTING DEPUTY DIRECTOR, BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE; AND GUY KING, DIRECTOR, OFFICE OF FINANCIAL AND ACTUARIAL ANALYSIS**

Ms. FEINSTEIN. Thank you. Sitting with me at the table is Bob Streimer, Acting Deputy Director of Health Care Financing at the Administration's Bureau of Eligibility, Reimbursement and Coverage.

In light of the increasing sophistication, size and complexity of these transctions, we share your concern. I will be summarizing my statement.

Chairman RANGEL. Your full statement will appear in the record.

Ms. FEINSTEIN. Thank you.

As you know, capital-related expenses presently are excluded from the new prospective payment system and paid essentially the same way they have over the last 18 years. Since our focus today concerns acquisitions and mergers, my testimony is directed at those elements of our capital policies substantially affected by such transactions.

In fiscal year 1984, the first year under prospective payment, expenditures for inpatient hospital operating costs are expected to total $39 billion. As the first chart shows, based on past experience we estimate that inpatient capital-related expenditures will be about $2.9 billion.

Of this total, $2.7 billion will be for depreciation and interest, and $200 million for return on equity. Capital-related expenditures will, therefore, represent about 7.5 percent of medicare payments for inpatient operating costs.

Approximately 70 percent of medicare's payments for capital are for depreciation, 24 percent for interest and 7 percent for return on equity. A cursory analysis of depreciation suggests that almost 80 percent is for fixed assets and 20 percent for movable assets.

While our data indicate that nationally capital costs are 7.4 percent of operating costs, there is considerable variation among hospitals. For roughly one-quarter of the hospitals depreciation and interest is less than 4 percent of operating costs. Slightly over one-half of those hospitals claim depreciation and interest that is between 4 and 10 percent of operating costs, and just under one-fifth have ratios between 10 and 20 percent.

In terms of depreciation expense is limited to the historical cost of the asset depreciated over its estimated useful life. Depreciation expense must be adjusted by gains or losses realized from the disposal of appreciable assets to reflect the actual costs of patient care.

Gains are recouped by medicare to the limit of the depreciation paid. Since losses represent an underpayment of costs, they are fully reimbursed.

A provider may include in its capital-related costs the costs of insurance for depreciable assets used for patient care or insurance

that provides for the payment of capital-related costs during business interruption.

Necessary and proper interest expense is included in capital-related costs. With few exceptions, we do not allow refinancing of existing debt if it costs the program additional amounts.

For proprietary providers a return on equity is allowed. As you know, the rate of return was reduced from 150 percent to 100 percent. Therefore, we estimate our return on equity outlays to be roughly $200 million in 1984, down from $300 million in the previous year.

The provider's fiscal intermediary is responsible for paying the provider on an interim basis for its capital-related costs. Upon settlement of the provider's cost report the intermediary must assure that the conditions and limitations applicable to capital-related costs expressed above have been met. Where the amount in controversy is at least $10,000, the provider may seek an administrative hearing before the Provider Reimbursement Review Board.

A recent GAO report, prepared in response to a request by Mr. Gradison, attempts to shed light on the potential consequences of complex transactions and the way in which medicare program costs may be affected. The report limits itself to a single complex merger between the Hospital Corp. of America and Hospital Affiliates.

Although we do not agree with all the details of the analysis, the report is a useful case study regarding issues that are of concern in the capital reimbursement area. While we are eager to see a resolution as to how capital-related costs should be treated in relation to the hospital prospective payment system, there are issues we need to address now, such as the method of allocating debt to patient care assets; the treatment of favorable financing and valuation of acquired lease contracts; and the standards and methods used in appraisals in general.

The GAO report recommends that our fiscal intermediaries consider their findings in making final determinations regarding the affected providers' cost reports, and that our policy guidelines relating to the issues described above be clarified.

We are working closely with the fiscal intermediaries serving the providers involved and the Blue Cross Association to settle the affected cost reports. In this process the GAO recommendations are being given careful consideration. In addition, we are evaluating our current capital-related cost findings in light of the GAO findings.

In conclusion, HCFA welcomes this opportunity to examine our mutual concerns over the treatment of these major elements of capital reimbursement to hospitals in a rapidly changing health care system. As a result of our reviews we hope not only to be able to clarify our current cost reimbursement policies for capital-related expenses but also to gain insights which will assist us in developing recommendations on how capital financing for hospitals should be included in the new prospective payment system.

I would be happy to answer your questions.

[The prepared statement follows:]

STATEMENT OF PATRICE HIRSCH FEINSTEIN, ASSOCIATE ADMINISTRATOR FOR POLICY HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

THANK YOU FOR THIS OPPORTUNITY TO COME BEFORE YOU TO DISCUSS THE IMPACT OF MERGERS AND ACQUISITIONS ON MEDICARE PROGRAM COSTS. SITTING WITH ME AT THE TABLE ARE ROBERT STREIMER, ACTING DEPUTY DIRECTOR OF THE HEALTH CARE FINANCING ADMINISTRATION'S BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE, AND GUY KING, DIRECTOR OF OUR OFFICE OF FINANCIAL AND ACTUARIAL ANALYSIS. IN LIGHT OF THE INCREASING SOPHISTICATION, SIZE AND COMPLEXITY OF THESE TRANSACTIONS, WE SHARE YOUR CONCERN OVER THESE CAPITAL FINANCING ASPECTS OF THE PROGRAM. AS YOU KNOW, CAPITAL-RELATED EXPENSES PRESENTLY ARE EXCLUDED FROM THE NEW PROSPECTIVE PAYMENT SYSTEM. THUS, WE CONTINUE TO REIMBURSE THESE EXPENSES ON THE SAME RETROSPECTIVE COST BASIS ESTABLISHED AT THE BEGINNING OF MEDICARE OVER 18 YEARS AGO.

BECAUSE MEDICARE IS A PUBLICLY FINANCED PROGRAM, CARE MUST BE TAKEN TO ENSURE THAT THESE PROGRAM PAYMENTS ACCURATELY REFLECT THE COST OF CARE TO OUR BENEFICIARIES. IN ADDITION TO GENERALLY-ACCEPTED ACCOUNTING STANDARDS IN THE PRIVATE SECTOR, THERE ARE SPECIFIC MEDICARE STANDARDS DUE TO THE PROGRAM'S UNIQUE RESPONSIBILITIES AND NEEDS. THESE STANDARDS ARE AUTHORIZED BY THE MEDICARE STATUTE AND HAVE BEEN IMPLEMENTED THROUGH REGULATIONS AND OUR PROVIDER REIMBURSEMENT MANUAL.

SINCE OUR FOCUS TODAY CONCERNS ACQUISITIONS AND MERGERS, MY TESTIMONY IS DIRECTED TO THOSE ELEMENTS OF OUR CAPITAL POLICIES SUBSTANTIALLY AFFECTED BY SUCH TRANSACTIONS:

DEPRECIATION, INTEREST EXPENSE AND RETURN ON EQUITY CAPITAL. THESE THREE ELEMENTS COMPOSE VIRTUALLY ALL OF TOTAL INPATIENT CAPITAL-RELATED EXPENSES.

## CAPITAL EXPENDITURES

IN FISCAL YEAR 1984, THE FIRST YEAR UNDER THE NEW PROSPECTIVE PAYMENT SYSTEM, EXPENDITURES FOR INPATIENT HOSPITAL OPERATING COSTS ARE EXPECTED TO TOTAL $39 BILLION. BASED ON PAST EXPERIENCE, WE ESTIMATE THAT INPATIENT CAPITAL-RELATED EXPENDITURES WILL BE ABOUT $2.9 BILLION. OF THIS TOTAL, $2.7 BILLION WILL BE FOR DEPRECIATION AND INTEREST AND $200 MILLION FOR RETURN ON EQUITY. CAPITAL-RELATED EXPENDITURES WILL THEREFORE REPRESENT ABOUT 7.4 PERCENT OF MEDICARE PAYMENTS FOR INPATIENT HOSPITAL OPERATING COSTS.

APPROXIMATELY 70 PERCENT OF MEDICARE'S PAYMENTS FOR CAPITAL ARE FOR DEPRECIATION, 24 PERCENT FOR INTEREST AND 7 PERCENT FOR RETURN ON EQUITY. A CURSORY ANALYSIS OF DEPRECIATION SUGGESTS THAT ALMOST 80 PERCENT IS FOR FIXED ASSETS AND 20 PERCENT FOR MOVABLE ASSETS.

WHILE OUR DATA INDICATE THAT, NATIONALLY, CAPITAL COSTS ARE 7.4 PERCENT OF OPERATING COSTS, THERE IS CONSIDERABLE VARIATION AMONG HOSPITALS. FOR ROUGHLY ONE QUARTER OF THE HOSPITALS, DEPRECIATION AND INTEREST IS LESS THAN 4 PERCENT OF OPERATING COSTS. SLIGHTLY OVER ONE HALF OF

THE HOSPITALS CLAIM DEPRECIATION AND INTEREST THAT IS BETWEEN 4 AND 10 PERCENT OF OPERATING COSTS. JUST UNDER ONE-FIFTH HAVE RATIOS BETWEEN 10 AND 20 PERCENT.

NOW I WOULD LIKE TO TURN TO A MORE DETAILED DESCRIPTION OF THE KEY CAPITAL COMPONENTS: DEPRECIATION, INTEREST EXPENSE AND RETURN ON EQUITY CAPITAL.

DEPRECIATION

UNDER MEDICARE, DEPRECIATION EXPENSE IS LIMITED TO THE HISTORICAL COST OF THE ASSET DEPRECIATED OVER ITS ESTIMATED USEFUL LIFE. WHERE AN ONGOING FACILITY IS ACQUIRED BY PURCHASE OR MERGER FROM AN UNRELATED ORGANIZATION, REVALUATION IS ALLOWED, BUT THE COST LIMIT REMAINS. THE HISTORICAL COST IS DEFINED AS THE LEAST OF THE PRICE PAID, FAIR MARKET VALUE OR CURRENT REPRODUCTION COST DEPRECIATED ON A STRAIGHT-LINE BASIS TO THE DATE OF PURCHASE. IN ESTABLISHING USEFUL LIFE, PROVIDERS MUST USE USEFUL LIFE GUIDELINES APPROVED BY THE SECRETARY. DEPRECIATION EXPENSE INCLUDES DEPRECIATION ON BETTERMENTS AND IMPROVEMENTS AND MINOR EQUIPMENT WHERE THE POLICY OF THE PROVIDER IS TO CAPITALIZE MINOR EQUIPMENT.

DEPRECIATION EXPENSE MUST BE ADJUSTED BY GAINS OR LOSSES REALIZED FROM THE DISPOSAL OF DEPRECIABLE ASSETS TO REFLECT THE ACTUAL COSTS OF PATIENT CARE. GAINS, WHICH REPRESENT AN OFFSET OF PREVIOUSLY REIMBURSED COSTS, ARE RECOUPED

BY MEDICARE TO THE LIMIT OF THE DEPRECIATION PAID IN FORMER YEARS. SINCE LOSSES REPRESENT AN UNDERPAYMENT OF COSTS, THEY ARE FULLY REIMBURSED. IN THIS ADJUSTMENT PROCESS, PAYMENTS OF ACCELERATED DEPRECIATION WHICH EXCEED THE STRAIGHT LINE DEPRECIATION SCHEDULE MAY BE RECOVERED BY THE PROGRAM. ACCELERATED METHODS OF DEPRECIATION MAY NOT BE USED FOR ASSETS ACQUIRED AFTER JULY 31, 1970, EXCEPT WHERE THE CASH FLOW FROM STRAIGHT-LINE DEPRECIATION IS INSUFFICIENT TO MEET REASONABLE PRINCIPAL AMORTIZATION SCHEDULES. IN THIS CASE, THE DECLINING BALANCE METHOD, NOT TO EXCEED 150 PERCENT OF THE STRAIGHT-LINE METHOD, MAY BE USED.

A PROVIDER MAY INCLUDE IN ITS CAPITAL-RELATED COSTS THE COSTS OF INSURANCE FOR DEPRECIABLE ASSETS USED FOR PATIENT CARE OR INSURANCE THAT PROVIDES FOR THE PAYMENT OF CAPITAL-RELATED COSTS DURING BUSINESS INTERRUPTION. TAXES ON LAND OR DEPRECIABLE ASSETS USED FOR PATIENT CARE ARE ALSO AN ACCEPTED ELEMENT OF CAPITAL-RELATED COSTS.

## INTEREST

NECESSARY AND PROPER INTEREST EXPENSE IS INCLUDED IN CAPITAL-RELATED COSTS, IF SUCH EXPENSE IS INCURRED IN (1) ACQUIRING LAND AND/OR DEPRECIABLE ASSETS USED FOR PATIENT CARE, OR (2) REFINANCING EXISITING DEBT, IF THE ORIGINAL PURPOSE OF THE REFINANCED DEBT WAS TO ACQUIRE LAND AND/OR DEPRECIABLE ASSETS USED FOR PATIENT CARE. WITH FEW EXCEPTIONS, WE DO NOT ALLOW REFINANCING OF EXISTING DEBT IF IT COSTS THE

PROGRAM ADDITIONAL AMOUNTS. TO ASSURE THE NECESSITY OF INTEREST EXPENSE, INVESTMENT INCOME MUST BE USED TO REDUCE INTEREST EXPENSE, EXCEPT WHERE SUCH INVESTMENT INCOME IS FROM UNRESTRICTED GIFTS OR GRANTS, FUNDED DEPRECIATION OR A PROVIDER'S QUALIFIED PENSION FUND.

## RETURN ON EQUITY CAPITAL

FOR PROPRIETARY PROVIDERS, A RETURN ON EQUITY CAPITAL IS ALLOWED. FOR ASSETS RELATED TO INPATIENT HOSPITAL SERVICES, THIS RETURN IS DETERMINED BY APPLYING TO THE PROVIDER'S EQUITY CAPITAL (EXCESS OF PATIENT-CARE-RELATED ASSETS OVER PATIENT-CARE-RELATED LIABILITIES) A PERCENT EQUAL TO THE AVERAGE RATES OF INTEREST ON SPECIAL ISSUES OF PUBLIC DEBT OBLIGATIONS ISSUED TO THE FEDERAL HOSPITAL INSURANCE TRUST FUND. AS YOU KNOW, THE RATE OF RETURN FOR INPATIENT HOSPITALS WAS RECENTLY REDUCED FROM 150 PERCENT TO 100 PERCENT OF THE RETURN ON TRUST FUND OBLIGATIONS. THEREFORE, WE ESTIMATE OUR RETURN-ON-EQUITY OUTLAYS TO BE ROUGHLY $200 MILLION IN 1984, DOWN FROM $300 MILLION IN 1983.

## IMPLEMENTATION OF HCFA POLICIES

THE PROVIDER'S FISCAL INTERMEDIARY IS RESPONSIBLE FOR PAYING THE PROVIDER ON AN INTERIM BASIS FOR ITS CAPITAL-RELATED COSTS. UPON FINAL SETTLEMENT OF THE PROVIDER'S COST REPORT,

THE INTERMEDIARY MUST ASSURE THAT THE CONDITIONS AND LIMITATIONS APPLICABLE TO CAPITAL-RELATED COSTS EXPRESSED ABOVE HAVE BEEN MET. WHERE THE INTERMEDIARY'S FINAL DETERMINATION OF THE AMOUNT DUE DIFFERS FROM THAT CLAIMED BY THE PROVIDER AND THE AMOUNT IN CONTROVERSY IS AT LEAST $1,000 BUT LESS THAN $10,000, THE PROVIDER MAY SEEK AN ADMINISTRATIVE HEARING BEFORE AN INTERMEDIARY HEARING OFFICER. THE HEARING OFFICER'S DECISION IS FINAL AND BINDING ON ALL PARTIES TO THE HEARING, UNLESS REVERSED OR MODIFIED BY THE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION.

WHERE THE AMOUNT IN CONTROVERSY IS AT LEAST $10,000, THE PROVIDER MAY SEEK AN ADMINISTRATIVE HEARING BEFORE THE PROVIDER REIMBURSEMENT REVIEW BOARD. THE SECRETARY, ON HER OWN MOTION, MAY ELECT TO REVIEW ANY DECISION OF THE BOARD. PROVIDERS MAY OBTAIN JUDICIAL REVIEW OF ANY FINAL DECISION OF THE BOARD OR OF ANY REVERSAL, AFFIRMATION OR MODIFICATION OF A BOARD DECISION BY THE SECRETARY, BY A CIVIL ACTION COMMENCED WITHIN 60 DAYS OF THE FINAL DECISION BY THE BOARD OR THE SECRETARY.

GENERAL ACCOUNTING OFFICE (GAO) REPORT

A RECENT GAO REPORT, PREPARED IN RESPONSE TO A REQUEST BY MR. GRADISON, ATTEMPTS TO SHED LIGHT ON THE POTENTIAL CONSEQUENCES OF COMPLEX TRANSACTIONS AND THE WAY IN WHICH MEDICARE'S PROGRAM COSTS MAY BE AFFECTED. THIS REPORT LIMITS ITSELF TO A SINGLE COMPLEX MERGER BETWEEN

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THE HOSPITAL CORPORATION OF AMERICA (HCA) AND HOSPITAL AFFILIATES INTERNATIONAL, INC. IN WHICH HCA IS THE SURVIVING CORPORATION.

ALTHOUGH WE MAY NOT AGREE WITH ALL THE DETAILS OF THE ANALYSIS, THE REPORT IS A USEFUL CASE STUDY REGARDING ISSUES THAT ARE OF CONCERN IN THE CAPITAL REIMBURSEMENT AREA. WHILE WE ARE EAGER TO SEE A RESOLUTION AS TO HOW CAPITAL-RELATED COSTS SHOULD BE TREATED IN RELATION TO THE HOSPITAL PROSPECTIVE PAYMENT SYSTEM, THERE ARE ISSUES WE NEED TO ADDRESS NOW, SUCH AS:

1. THE METHOD OF ALLOCATING DEBT TO PATIENT CARE ASSETS;

2. THE TREATMENT OF FAVORABLE FINANCING AND VALUATION OF ACQUIRED LEASE CONTRACTS; AND

3. THE STANDARDS AND METHODS USED IN APPRAISALS IN GENERAL.

THE GAO REPORT RECOMMENDS THAT OUR FISCAL INTERMEDIARIES CONSIDER THEIR FINDINGS IN MAKING FINAL DETERMINATIONS REGARDING THE AFFECTED PROVIDERS' COST REPORTS, AND THAT OUR POLICY GUIDELINES RELATING TO THE ISSUES DESCRIBED BE CLARIFIED.

YOU WILL BE PLEASED TO KNOW THAT WE ALREADY ARE WORKING CLOSELY WITH THE FISCAL INTERMEDIARIES SERVING THE PROVIDERS INVOLVED AND THE BLUE CROSS ASSOCIATION TO SETTLE THE AFFECTED COST REPORTS. IN THIS PROCESS, THE GAO RECOMMENDATIONS ARE BEING GIVEN CAREFUL CONSIDERATION. IN ADDITION, WE ARE EVALUATING OUR CURRENT CAPITAL-RELATED COST FINDINGS IN LIGHT OF THE GAO FINDINGS.

CONCLUSION

IN CONCLUSION, HCFA WELCOMES THIS OPPORTUNITY TO EXAMINE OUR MUTUAL CONCERNS OVER THE TREATMENT OF THESE MAJOR ELEMENTS OF CAPITAL REIMBURSEMENT TO HOSPITALS IN A RAPIDLY CHANGING HEALTH CARE SYSTEM. AS A RESULT OF OUR REVIEWS, WE HOPE NOT ONLY TO BE ABLE TO CLARIFY OUR CURRENT COST-REIMBURSEMENT POLICIES FOR CAPITAL-RELATED EXPENSES, BUT ALSO TO GAIN INSIGHTS WHICH WILL ASSIST US IN DEVELOPING RECOMMENDATIONS ON HOW CAPITAL FINANCING FOR HOSPITALS SHOULD BE INCLUDED IN THE NEW PROSPECTIVE PAYMENT SYSTEM AS IT MATURES.

I WILL BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Chairman RANGEL. Ms. Feinstein, what you are saying is that if Mr. Gradison had not requested this report, that HCFA would not have raised this before the Congress.

Ms. FEINSTEIN. No, I do not think so, Mr. Rangel. We estimate about 200 merger and acquisition transactions between single hospital facilities in a given year for which we are reasonably comfortable that our policy is both articulated well and implemented rather uniformly by our intermediaries.

Chairman RANGEL. Well, when you see those dramatic increases in Federal expenses, is there not somebody in your shop that says let us take another look at this? I mean, you are not satisfied with the reimbursement method which we are using now, are you?

Ms. FEINSTEIN. No; I think we ought to move as rapidly as we possibly can to put capital costs into the prospective payment rates.

Chairman RANGEL. Who OK'ed the transaction that is the subject matter of the GAO report?

Ms. FEINSTEIN. The transaction has been addressed with respect to whether or not a statutory merger took place, and we have sent word back to the intermediaries that that has occurred.

With respect to finalizing all of the details of this particular merger, I guess I could portray it as we are still in conversation with both the intermediary and HCA and that matter is not closed.

Chairman RANGEL. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

I leaned kind of hard earlier in the hearing on the Blue Cross/Blue Shield folks because I felt that they were the intermediaries and probably were doing a lot of work on this matter, but maybe, judging by the response, I leaned in the wrong place, so I want to lean now on you.

My understanding under the law is that once the General Accounting Office makes a report, as in this case involving HHS, that the Department has 60 days in which to give its specific comments to the Congress on the issues raised in the report.

I do not know precisely what day the report actually reached the Department. I do know that on January 18 I wrote the Secretary and enclosed a copy of the report and more than 60 days has gone by.

One thing I did not pick up from your testimony, I understand you are working on it, and that is what your testimony says, but when can we expect to receive a detailed report on each of the points raised by the General Accounting Office report with regard to the accounting treatment and other issues in the acquisition by HCA of HAI—what date?

Ms. FEINSTEIN. Mr. Gradison, I cannot give you a date precisely today. My attorneys have advised me that this matter will likely be under litigation so I am not at liberty to discuss with you today the specifics of this particular case.

I believe that the specific recommendations that GAO made—namely that we clarify medicare guidelines as it relates to two or three specific areas—I can commit to you that we are very seriously entertaining the question. It is taking some time because of the issue of whether we need new regulations or new statutory authority, or whether some of these matters may be clarified through manual clarifications and conversations with our intermediaries.

But I think the generic nature of the recommendations—that we clarify guidelines relating to the allocation of debt, to the discounting of assumed debt, and to valuation methods—are areas that we are very, very seriously addressing.

Mr. GRADISON. I can understand your reluctance to discuss this specific case, and I do not want to press that. Let us stick to the level of review of this on a generic basis.

Are you considering the possibility of having matters of this kind which involve complex acquisitions and mergers handled in a somewhat more centralized manner rather than by the intermediaries that happen to have responsibility for the home office area of the acquiring company?

Ms. FEINSTEIN. I think that also is an issue that we are presently considering. As you know, our contracting strategy has moved away from each intermediary handling the specific needs of the hospital, skilled nursing facility, or home health agency in a particular area. For complex matters, we have moved to regional intermediaries in home health.

Additionally, we are considering perhaps regionalizing and streamlining the number of intermediaries who would review these kinds of complex mergers.

Mr. GRADISON. In that connection, one of the points raised by the General Accounting Office had to do with the question of whether or not the independent appraiser was really independent and whether, to be more precise, the independence of the appraiser was compromised by contacts made by the accountants of Hospital Corp. of America with that appraiser prior to the completion and submission of the appraisal report to HCA.

Without reference to this particular case—and I do not intend to ask names; I just want to make sure how this works—would you have as a department access to the appraisal reports?

Mr. STREIMER. Mr. Gradison, the fiscal intermediary has access to the appraisal reports.

Mr. GRADISON. And would the fiscal intermediary be expected to look behind these reports and perhaps even to have an additional appraiser hired by the Government or have the intermediary take a look at the appraisals, or would the appraisal done by the alleged independent appraiser be considered the last word—as a general matter?

Mr. STREIMER. I think as a matter of history we are unaware of any situation where an appraisal has been rejected. We are seriously considering ways we could strengthen our requirements with respect to appraisals.

Mr. GRADISON. Well, your own Inspector General, quite apart from the HCA issue, has pointed to some rather curious appraisals. One that fascinated me was that the acquiring company had an appraisal done on the basis of the standards used by that company for new building of hospitals—I guess that is the square foot standard or something of the sort— rather than appraising the building as is. That as much as anything in the HCA case leads me to wonder whether you do not have to look at least back to the assumptions in order to get a balanced view of whether this is being handled equitably around the country.

In the cases raised by your own Inspector General are you through normal internal processes, through the use of your intermediaries, reviewing the appraisals that were accepted in those specific instances brought to your attention by your own Inspector General?

Mr. STREIMER. We just became aware of those in the last day or two. The Inspector General's report has just been received, I believe this morning, so we will be looking into those, and that will assist us in our evaluation of any steps we need to take in strengthening our appraisal policies.

All we have now in our manuals and instructions after 18 years under the program are very broad situation descriptions of when an appraisal would be useful. We have never gone beyond that, and that is an area we need to address.

Mr. GRADISON. The Finance Committee in the other body has included within its omnibus tax spending recommendations a moratorium which, as I understand it, would on a prospective basis, beginning October 1 of this calendar year, halt upward revaluations in situations like the one covered by the General Accounting Office report.

Does your department have any recommedations with respect to this legislative proposal, which we may very well face in conference if we do not act upon it ourselves?

Ms. FEINSTEIN. Mr. Gradison, in reference to that particular piece of legislation, we have some very serious concerns about the cost estimates even though we have not yet had an opportunity to review the detailed language. Some of the other people who do estimates in town are carrying a savings from instituting that kind of a policy. Whereas no doubt there would be savings from that kind of a policy over the long haul, our actuaries have serious concerns that in the short term—the first year or two—it is not only not a net savings, it is a net cost item.

And given the precarious nature of our trust funds today, it would seem unwise to me to enact something that would only further exacerbate the situation of the trust funds. Surely if we fold capital into prospective payment rates in a large manner we have mooted that issue, and I think that is a more preferable way to go.

Mr. GRADISON. Could you explain the mechanism that would lead to higher costs in the earlier years?

Ms. FEINSTEIN. I am going to ask Mr. Guy King, our chief actuary in HCFA, to join me at the table with that explanation.

Chairman RANGEL. Did you hear the question?

Mr. KING. Yes, I did, Mr. Chairman.

Mr. Gradison, the reason we feel there will be an additional outlay to the trust fund associated with the Senate Finance Committee's proposal is because right now under the current medicare reimbursement rules, as you know, every time one of these mergers or acquisitions takes place the medicare program recovers, if the institution is sold at a profit, all of the depreciation that has been paid to that institution to date.

Mr. GRADISON. Are you saying that that is the rule or that is actually the practice? It is our understanding that there is some question as to whether that has uniformity, whether the rules have been administered in that manner in the past.

Mr. KING. Well, my understanding is that the rules are enforced, and I have heard testimony earlier today that suggested that sometimes the recoupment of those depreciation payments is spread out over a number of years. I do not know why that has to happen because it is a recoupment from the proceeds of the sale of the institution.

Mr. GRADISON. Well, the testimony was that it can be several years later and because of the time value of money there is not really a full recoupment. Furthermore, if there is an average of 2 or 3 years' delay, which was the testimony we had on this point earlier, then that would not affect those early budget years, which are the years that you are addressing yourselves to.

So the actual practice I think has to be examined, as well as just what your regulations say on paper.

Mr. KING. Well, there does not have to be a 2- or 3-year delay in the recovery of those payments. That is something that could be addressed under current regulations and current law.

Mr. STREIMER. Mr. Gradison, our rules specifically require the recovery to occur in the year the selling organization files its cost report, immediately upon the sale. We have no information at all that there is a long delay in recovering that money. This morning was the first instance we have heard that there was any delay, and I expect it is in very few cases.

Chairman RANGEL. Would the gentleman yield?

Mr. GRADISON. Of course.

Chairman RANGEL. Why would there be a question as to whether you would know whether there was a delay or not? I mean, with the team that you have brought here, would you not know whether it was a fact or not a fact?

Ms. FEINSTEIN. We do not believe there is a delay in the recapture. We believe it does take place.

Chairman RANGEL. I hear what you are saying, but is this one of those fuzzy things where you can believe or not believe? I mean, would you not know?

Ms. FEINSTEIN. We think we do know. As I think Mr. Streimer suggested, we have not had an opportunity to see the Inspector General report at this time, and whereas he may have found somewhere where that happened once, we do not believe as a general rule that happens.

Chairman RANGEL. Have you responded to the Senate legislation over there at all with the reservations that you have here today?

Ms. FEINSTEIN. We have informally.

Chairman RANGEL. I yield back.

Mr. GRADISON. Well, Mr. King, you were talking about how this works itself out, and I gathered so far you are saying that the recoveries in the early years would exceed the costs which result from revaluation in the early years; is that correct?

Mr. KING. Yes; in the first year the recoveries under any reasonable scenario would substantially exceed the additional depreciation and interest payments that would be made. What we have is a one-time recovery. We do not get that any more. Then, as time passes, the additional depreciation and interest that we are paying would eventually eliminate the initial savings, but on a cash flow

basis the short-term effect is to increase the outlays of the trust fund.

Mr. GRADISON. But are you not assuming, then, that a moratorium on revaluations will substantially reduce the number of acquisitions and mergers in order to arrive at that conclusion? I do not reach that conclusion myself.

I think that these things are driven more by tax considerations than anything we are talking about here today. Therefore, that the transaction and recapture would take place whether we do something or we do not do anything. So, in my method of calculating I can say it largely would cancel itself out.

So let me come back to the premise. Are you assuming that there will be substantially less acquisitions and mergers as a result of the moratorium and, if so, why?

Mr. KING. Well, for one thing CBO in its writeup pointed out that it thought that this would be a deterrent to mergers and acquisitions, but it does not really matter whether it is a deterrent or not. The problem is still there unless you are willing to craft the legislation in such a way—and we have not seen actual language in the Senate Finance Committee recommendation—to produce a savings under even the best scenario, which is a situation where mergers and acquisitions take place regardless of this new policy having been implemented.

Even under that scenario, the Congress is going to have to write the legislation to say to the seller for the purposes of recovery of past payments for depreciation we value your asset at the original purchase price that you paid, and then you have to turn around to the buyer and say, but for purposes of paying future depreciation to you we value the asset at the depreciated current book value.

That is the only way that the legislation could be written in order to produce a savings.

Mr. GRADISON. Well, I think it would be very helpful to the subcommittee if you could make available to us your studies on this point and particularly your cost estimates. I have nothing to go on other than my own judgment and the report of the General Accounting Office.

In the particular case which was mentioned, the gain recoverable to the medicare program—and this was the largest acquisition in the history of the hospital industry; it involved 54 hospitals—the gain recoverable was $6 million. But the additional cost to the medicare program in the first year was a whale of a lot more than $6 million.

Now perhaps I misread the figures. Perhaps that, was an atypical acquisition, but in any event could you make your numbers available to us so we can study it without taking additional time in this hearing?

Mr. KING. But before we make our numbers available I would like to say that, in order to do an actual cost estimate on something like this, one would have to be able to actually predict what the rate of future acquisitions is going to be, what the level of the depreciated assets was when the acquisition was made, and what the relationship is between the purchase price and the depreciated level of the assets. There are so many absolutely unpredictable

variables in that equation that it would be impossible to do the cost estimate.

We do not have a cost estimate for it, but I think we can show you a scenario that we have developed that shows that even under the most favorable circumstances it will be at least 3 years before there is any reduction in outlays to the medicare program because of it.

Mr. GRADISON. Well, why do you not show that to us on paper? We have a proposal in the Senate Finance version which we very well may see in conference, whether this committee does anything about it or not.

We also have a tradition around here for budgetary purposes of using for scorekeeping on budget matters the figures of the Congressional Budget Office, which in this instance shows a savings of $750 million for medicare over a 5-year period, and $80 million for medicaid.

That may be dead wrong; I really do not know. But until we get something from you in writing that we can send to them and use as a basis for some figures, when we get into the exercise in the House of Representatives, which we may well be pushed into very early by the budget process, of coming up with additional savings, I assure you that is how score is going to be kept unless we get evidence that the figures are wrong.

So all I am asking is for you to share with us what you have. We understand the uncertainties and the variables, but this is not just a theoretical idea any more. It has some chances of being enacted into legislation by virtue of the pressure that is being put on all of us to come up with better budget numbers and lower deficits over the next 3 years. I acknowledge that; that is over the next 3 years.

Thank you, Mr. Chairman.

Chairman RANGEL. Well, I want to thank you, Mr. Gradison, for bringing this to the attention of the Congress and the administration. We are being asked to cut the medicare budget by $3 or $4 billion, and we certainly hope that you would be able to help us in doing that rather than allow just political considerations to prevail.

I would like to join with Mr. Gradison in asking you to share with us how you reach these conclusions which are so dramatically different from the testimony received earlier today.

Again, I thank you.

Mr. GRADISON. Would the chairman yield?

Mr. Chairman, I think it would be helpful in view of the important questions raised by the representatives of HHS about cost if we were to request the General Accounting Office's comments in writing on this question of cost, and I am not expecting detailed estimates.

I realize there are uncertainties that make it difficult to do, but the thrust of your argument, as I understand it, is that while there may be long-term savings there are short-term costs on balance. Is that a fair statement?

Ms. FEINSTEIN. Yes.

Mr. GRADISON. I think it would be helpful if we had any comments which the General Accounting Office might be in a position to make. If they cannot make any, they cannot make any, but if

they can I would at this point like to suggest, Mr. Chairman, we request such comments in writing.

Chairman RANGEL. I agree, and so order.

[The record was left open for 60 days for the administration to provide either a cost estimate or an example supporting the administration's position where there might be long-term savings from a proposal limiting the revaluation of assets, but in the short run there would be a cost. The administration did not respond to the request of the committee. Therefore, the record is being closed without the response of the administration.

[The General Accounting Office was also requested to comment on the question of cost. The GAO response follows:]

U.S. GENERAL ACCOUNTING OFFICE,
HUMAN RESOURCES DIVISION,
*Washington, D.C., April 5, 1984.*

Hon. CHARLES B. RANGEL,
*Chairman, Subcommittee on Oversight,*
*House Committee on Ways and Means.*

Hon. ANDREW JACOBS, Jr.,
*Chairman, Subcommittee on Health,*
*House Committee on Ways and Means.*

DEAR MESSRS. CHAIRMEN: At the close of joint hearings before the Subcommittees at which we testified on the issue of revaluation of assets under medicare after sales of hospitals, you asked that we comment for the record on the Health Care Financing Administration's (HCFA's) position that a bill to control revaluations under consideration in the United States Senate would, in the short term, increase medicare's costs. HCFA's position as stated by its representatives at the hearing was that, if the buyer was not allowed to revalue assets after an acquisition, HCFA would no longer be able to share in the gain the seller realized on the sale. The HCFA representatives stated that this would result in a short-term net increase in medicare costs. Apparently, HCFA believes that it could not sustain on challenge a policy that shares in the seller's gain on the one hand but does not permit the buyer to revalue assets based on its purchase price on the other hand.

Current Medicare policy treats sharing in the seller's gain and the buyer's revaluation of purchased assets as two separate and distinct occurrences. Regarding sharing in the seller's gain when a bona fide sale is involved, Medicare regulations (42 C.F.R. 405.415(f)) state:

". . . If disposal of a depreciable asset results in a gain or loss, an adjustment is necessary in the provider's allowable cost. The amount of a gain included in the determination of allowable cost shall be limited to the amount of depreciation previously included in Medicare allowable costs. The amount of a loss to be included shall be limited to the undepreciated basis of the asset permitted under the program . . . The extent to which such gains and losses are included is calculated by prorating the basis for depreciation of the asset in accordance with the proportion of the assets useful life for which the provider participated in Medicare."

The rationale for sharing in the seller's gain is an follows. Under Medicare, depreciation is a payment made to cover the value of an asset that is used up during the period of time in question due to wear and tear, functional obsolence, etc. Depreciation is generally computed by dividing the allowable purchase price of an asset by its estimated useful life and including as a cost each year the amount so derived. If the useful life is correctly estimated, when an asset is of no further value to the owner, it will be fully written off. If the seller is paid more than the depreciated book value of an asset upon its sale (and, therefore, realizes a gain), under the theory outlined above the useful life of the asset was incorrectly estimated and too much depreciation was allowed. As a result, Medicare should share in the gain to the extent that its payments for depreciation exceeded the actual decline in the value of the sold asset as measured by the selling price.

Regarding revaluation by the buyer based on its allowable purchase price, medicare regulations (42 C.F.R. 405.415(g)) state:

". . . The cost basis for the assets of a facility purchased as an ongoing operation after July 1, 1966, and before August 1, 1970, shall be the lowest of:

(i) The total price paid for the facility by the purchaser, as allocated to the individual assets of the facility; or

(ii) The total fair market value of the facility at the time of the sale, as allocated to the individual assets; or

(iii) The combined fair market value of the individually identified assets at the time of the sale. . . . For depreciable assets acquired after July 31, 1970, in addition to the limitations specified [above], the cost basis of the depreciable assets shall not exceed the current reproduction cost depreciated on a straight-line basis over the life of the assets to the time of the sale."

Thus, Medicare currently allows revaluation of acquired assets to reflect the lowest of purchase price, fair market value, or depreciated reproduction costs. If the new owner should subsequently resell the assets, Medicare would share in its gain (or loss) in the same manner discussed below.

From the prospective that the sharing in the seller's gain and the buyer's revaluation of acquired assets are two distinct occurrences, changing one of them would not effect the other. However, HCFA apparently believes that it would not be able to sustain on challenge the position that the two occurrences are separate and distinct and that, therefore, Medicare would no longer be able to share in the seller's gain. If HCFA's view on this is correct, the loss of sharing in the seller's gain could exceed in the short term the savings realized in depreciation, interest and return on equity, from restricting revaluation of assets after sales.

If the Congress decides that revaluation of assets after sales should be restricted and if the Congress decides that Medicare should continue to share in the seller's gains (and losses), the law could be amended to provide for both. From the prospective of fairness to current owners of assets, we see no problem with continuing to share in gains and losses after restricting asset revaluation for buyers, under the rationale for sharing outlined above. However, if revaluation of assets is restricted, owners who buy assets and subsequently resell those assets, could be unfairly treated if Medicare's share of the gains is based on the restricted asset valuation. It is possible on resale for the buyer to incur a loss based on its purchase price but to show a gain based on the restricted Medicare allowable depreciation basis. Thus, Medicare would share in a gain that in reality did not occur. This potential problem could be overcome by drafting the amendment to provide for sharing in gains based on the allowable purchase price that would have been recognized under the rules in force before the amendment of the law to restrict revaluation after sales.

I trust that our comments on this will be of assistance to the Subcommittees.

Sincerely yours,

MICHAEL ZIMMERMAN,
*Associate Director.*

Chairman RANGEL. I might also ask you to share your concerns about the Senate initiative to correct this. It is my understanding that members of Ways and Means are prepared to yield to their proposed solution. I do not say that as a fact, but if you have any reservations I say that to move you to speedily responding to what reservations you have to the Senate bill.

Thank you very much. The committee stands adjourned.

[Whereupon, at 1:27 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

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NEUROLOGY
OBSTETRICS, GYNECOLOGY
HIGH RISK OBSTETRICS
LASER SURGERY
REPRODUCTIVE ENDOCRINOLOGY
OPHTHALMOLOGY
ORAL & MAXILLOFACIAL SURGERY
ORAL PATHOLOGY & MEDICINE
ORTHOPEDIC SURGERY
GENERAL ORTHOPEDIC SURGERY
SURGERY OF THE HAND
ARTHROSCOPIC SURGERY
OTOLARYNGOLOGY
PATHOLOGY
PEDIATRICS
GENERAL PEDIATRICS
HEMATOLOGY ONCOLOGY
PSYCHIATRY
PSYCHOLOGY
RADIOLOGY
SPORTS MEDICINE
UROLOGY
CLINIC LOCATIONS
FARGO, ND
• 1702 S. University Dr.
• West Acres Mall
CASSELTON, ND
DETROIT LAKES, MN
FRAZEE, MN
LAKE PARK, MN

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WAYS AND MEANS
HEALTH SUBCOMMITTEE

February 21, 1984

Honorable Andrew Jacobs, Jr., Chairman
Ways and Means Committee
House of Representatives
SubCommittee on Health
1115 Longworth House Office Building
Washington, D.C. 20515

Dear Congressman Jacobs:

It has come to our attention that you will hold a joint hearing to examine the impact of hospital mergers and acquisitions on medicare program costs. This apparently was prompted by a GAO report stating that the acquisition of hospitals by for-profit chains and federal reimbursement for the interest and capital costs involved is increasing federal medicare and medicaid expenses.

We would like to comment on our experience with the for-profit management firm that has been in the hospital we use since 1981. On July 1, 1981, the Benedictine Sisters of Crookston, Minnesota, who own the hospital we use in Detroit Lakes, Minnesota, leased the hospital to American Health Care, Inc. of Dallas, Texas. This action was taken with minimal warning and with little consultation of the medical staff.

At a meeting of community leaders to introduce the new management officers, the President of American Health Care Inc. was asked how his firm expected to profit when non-profit management was having difficulty staying even with expenses. He said they expected to do better at controlling expenses. They have - by laying off more than 25% of the hospital personnel and by other cash flow control practices. He also said they could extract more money from the federal government through a one time large raise of allowable charges. He said the rules permitted for-profits to do this. One day before they took control they instructed the previous management to raise charges 20%. Three months later they raised charges another 20% for an aggregate raise of about 45%. Five months later they announced that charges would be raised another 20%, for an aggregate of about 70% in the first eight months.

The medical staff vigorously stated its opposition to this last raise. By then we had learned that in the first six months of their operation they had paid themselves very high administrative expenses and had taken $500,000.00 from our hospital to use in another of their managed hospitals. We felt that raises by 70% were totally unjustified. Because of our objections, they did not make the last raise at that

time, but since then they do not tell us about raises. It is our suspicion the raises have probably continued, but since we don't have access to their figures, we have no proof.

Our rough calculations indicate they have probably extracted at least one million dollars per year in profits. The year before they took over, the hospital grossed about four million dollars per year; through their raises they increased this gross to over seven million per year. They did this while reducing costs by reducing the number employed. They made minimal capital expenditures.

As mentioned, the medical staff was not consulted about this management transition. For awhile we were resigned to it and hoped that American Health Care would bring our hospital expert, modern management and we expected them to earn a profit from this, as we are strong supporters of the free-enterprise system that has made this country prosper. We expected them to make a profit, but not be opportunistic profiteers.

We invite you to scrutinize this new small for-profit company that may not have broken the rules, but certainly severely stretched them. We would love to see if a government audit confirms our suspicions.

Yours truly,

DAKOTA CLINIC, LTD.

John L. Hicks, D.D.S.
Vice President
Dakota Clinic, Ltd.

D. D. Wightman
President
Dakota Hospital

Robert A. Koshnick M.D.

Robert A. Koshnick, M.D.
Chief of Staff
St. Mary's Hospital

James A. Collinge, M. D.

John R. Emery, M. D.
Director
Dakota Clinic, Ltd.

James F. Knapp, M. D.

James F. Knapp M.D.

cc: Claude Pepper

STATEMENT OF HON. MIKE LOWRY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. Chairman: I appreciate the opportunity to appear at this hearing on the effects of changes in hospital ownership on Medicare expenditures. I commend my colleagues from Indiana and New York for their leadership in focusing attention on this most complex but important issue.

As a member of the House Budget Committee, I have been working with my colleagues to produce this year's first budget resolution. As you know, this is a difficult exercise in tradeoffs among vital budget priorities. Since 1981, Medicare spending has been reduced by $13.2 billion. The burden of these Medicare cuts have fallen primarily on beneficiaries through increased out-of-pocket costs. This year, President Reagan has recommended additional cuts and program changes which would futher increase costs to beneficiaries. Recognizing that further cuts in Medicare may be necessary, I would hope that the Congress would look to savings which can be achieved without shifting costs to beneficiaries or reducing access to care available under the Medicare program. I believe that in the subject of today's hearing, this committee has identified an area of Medicare spending ripe for reform.

We all know that the Medicare trust fund is in peril. It could go bankrupt within the next decade. But every time a hospital is sold, Medicare rules allow the hospital to increase its charges to Medicare, even though no improvements are made in patient services or in the hospital's facilities. A New York Times editorial has described this Medicare policy under the heading, "Medicare Whirring Money Machines." a recent GAO report shows how it costs Medicare millions of dollars. And the Congressional Budget Office has identified its reform as a way to produce $750 million in Medicare and $80 million in Medicaid savings over the next five years.

Why does the sale of a hospital cost Medicare money? Under existing Medicare rules, the owner of a hospital is allowed to bill Medicare for a portion of certain capital-related expenses. These include depreciation, interest on borrowed money, and a fair return on the owner's investment in the hospital if it is a for-profit facility. (The latter is also known as a "return on equity.") The portion of these expenses billed to Medicare is determined according to the hospital's Medicare patient population.

When the hospital is sold, the new owner is allowed to revalue the hospital's facilities and equipment, that is, to step up their value to a new level. This level is usually the purchase price of the hospital, which is, in turn, used to determine how much Medicare will reimburse the hospital for depreciation, interest expenses and a return on equity. The effect of this revaluation is that Medicare can end up paying for the asset a second time at a higher price. This is a costly and unjustifiable expenditure of Medicare funds.

Last year the GAO issued a report, requested by Congressman Gradison, which helped to bring this issue to the public eye. The report showed how the purchase of one major hospital chain by another resulted in significantly increased costs for Medicare. Because the hospitals changed hands, Medicare permitted the new owner to revalue its acquired assets. This increased the depreciation and interest costs of the purchased hospitals by $55 million. After examining the books of two hospitals involved in the merger, the GAO concluded that the sale had increased Medicare's costs by $26 and $21 per patient day respectively, although no improvements were made to the facilities or to the services provided to patients.

The GAO audit demonstrated how extremely costly hospital acquisitions can become for Medicare. It showed how, within a short period of time, a set of hospitals had been sold and then resold, each time being revalued upward, and each time adding to Medicare's costs. It pointed to the failure of the Health Care Financing Administration, which administers Medicare, to enforce existing regulations governing the extent to which interest and return on equity costs are allocated to Medicare when hospitals are sold. And it pointed to the inefficiencies encouraged by a system of reimbursement which requires Medicare to pay for marketplace transactions which produce no change in the quality or quantity of patient services.

More recently, the Congressional Budget Office had identified Medicare's capital reimbursement policies as an area for potential Medicare savings. Specifically, CBO estimates that we could achieve a five-year savings for Medicare of $750 million, and an $80 million savings to Medicaid, by disallowing revaluation for assets acquired in fiscal year 1985 and after, and by restricting the ability of hospitals to charge Medicare for the increased costs of interest and return on equity resulting from hospital sales.

On March 20, I introduced legislation to change the way in which Medicare reimburses hospitals for capital-related costs that result from the sale of hospital assets.

Under my bill, Medicare would no longer allow a hospital to revalue an asset upon its purchase for purposes of reimbursement. It would, in addition, strictly limit the amount Medicare pays for the increased costs of interest and return on equity resulting from the sale. It does this by limiting reimbursement for these expenses to the net-book value of the asset, which is defined as the value of the asset on the date prior to the change of ownership less accumulated depreciation. In sum, the bill is designed to insure that costs to Medicare do not increase just because the hospital has changed ownership. It does not affect, however, other forms of transfers of assets such as stock mergers or consolidations. These would remain subject to existing regulations.

This bill is not intended as a comprehensive solution to the capital costs issue. I hope that such a solution may be shaped before October, 1986, when capital costs are scheduled to be brought under the DRG prospective payment system. Instead, this bill is meant to provide a short-term way of saving Medicare funds in a manner that will not reduce benefits or increase cost-sharing for beneficiaries. Some of the largest hospital chains have indicated that they expect to spend many billions of dollars acquiring facilities over the next few years. My bill is unlikely to curb this acquisition fever since its driving force seems to be the accelerated depreciation provisions of the 1981 Economic Recovery Tax Act. However, unless we place a moratorium on revaluations for purposes of Medicare reimbursement, Medicare will end up paying millions of dollars for sales which will produce no change in patient services. My bill will provide this moratorium. I welcome the support of my colleagues for this measure.

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STATEMENT OF THE NATIONAL COUNCIL OF HEALTH CENTERS, PAUL R. WILLGING, EXECUTIVE VICE PRESIDENT

THE NEED FOR CAPITAL IN THE NURSING HOME INDUSTRY—HIGHLIGHTS

*I. Differences between nursing homes and hospitals*

Nursing homes are 80 percent investor-owned compared to hospitals, which are 20 percent investor-owned.

Nursing homes' occupancy rates are at 95 percent or higher; hospital occupancy is often in the area of 70–80 percent.

There is an oversupply of hospital beds; approximately 1.2 million new nursing home beds will be needed over the next 16 years to keep pace with the already inadequate supply.

*II. Capital needs of long-term care*

Approximately $58 billion in capital will be needed by the year 2000 to supply needed new nursing home beds.

Only the investor-owned segment of the nursing home industry has the financial resources to qualify for capital to build new beds.

The nursing home industry is currently experiencing a one percent annual growth rate; a rate of three and one-half percent is needed to match the growth in the elderly population.

*III. Need for small issue industrial development bonds*

Investor-owned nursing homes rely almost totally on small issue industrial development bonds for new construction.

The proposal in H.R. 4170 for a $40 million company cap on IDBs is irrelevant and would result in no savings if a state volume cap also is in place.

In competing for small issue IDBs, nursing homes have an additional obstacle to overcome, certificates of need, which requires financing sources be determined prior to application.

*IV. Investor-owned versus not-for-profit nursing homes*

Investor-owned nursing homes serve a higher proportion of indigent Medicaid patients than do tax-exempt or non-profit nursing homes.

Investor-owned nursing homes provide the same services at a much lower cost than either non-profit or government facilities.

Public policy may soon penalize efficient investor-owned nursing homes by denying them access to lower cost financing (small issue industrial development bonds) while continuing to make IDBs available to higher cost non-profit facilities.

*V. Effect of proposals to limit capital costs*

A fair Medicare rate of return on investment is essential to maintain and attract investors to the nursing home industry.

A freeze on asset revaluation will only lead to fewer beds being built and conversion of existing facilities into other uses.

*VI. Prospective payment for medicare skilled care*

The industry is seeking a payment system based on case mix rather than individual nursing home characteristics.

The treatment of capital should be discussed in tandem with the development of a prospective payment system.

An ideal system would establish a rate that includes capital costs but that obviates the need for consideration of each individual component of capital.

*VII. Summary*

The National Council of Health Centers recommends that the Committee:

Take no action to further restrict availability of small issue IDBs for nursing homes construction.

For the time being, preserve Medicare's present treatment of capital for nursing homes.

Discuss capital concurrently with, not separately from, developing a prospective payment system for Medicare skilled nursing facility care.

STATEMENT

The National Council of Health Centers appreciates this opportunity to discuss the role of capital in the long term care field and the need for a deliberative process in the debate surrounding its inclusion in a Medicare payment rate.

The National Council of Health Centers is the trade association that represents investor-owned nursing home corporations. Presently our membership has over 200,000 nursing homes beds or about 15 percent of the total beds in this country.

Although most of the discussions on Capitol Hill, at the Department of Health and Human Services, and in the Health community have focused on the capital needs and problems of hospitals, our statement will deal only with nursing homes. Many individuals mistakenly believe that the characteristics of hospitals and nursing homes, i.e., patient mix, financial needs and reimbursement policies, are much the same. And, by extrapolation, that discussions relating to capital costs apply equally to both industries. The purpose of this statement is to set forth the relevant differences between the hospital and the nursing home industries so that further debate on the issues in question, capital costs and capital formation, can be conducted with an awareness and an appreciation of these differences.

I. DIFFERENCES BETWEEN NURSING HOMES AND HOSPITALS

The nursing home industry is largely proprietary. Some 80 percent of America's 22,000 nursing homes are investor-owned. By constrast, the ratio is exactly opposite in the hospital industry: 20 percent are investor-owned, 80 percent are non-profit. The primary reason for these opposite ratios is that hospitals had available billions of dollars in Hill-Burton funding beginning in the 1950's while growth in the nursing home industry was almost entirely dependent upon private investment. Without private capital, 70 percent of this country's nursing homes would never have been built.

The greying of America has become a commonly used term in our vocabulary, yet it is hard to grasp the implications of what this term means for long term care. In 1982 approximately 12 percent of our population, on one of every eight, was 65 years of age or older (21 million Americans). By the year 2010, one of every seven people will be over 65 (34.3 million). Even more critical is the number of persons aged 85 or older, which will more than triple to 6.8 million early Americans. It is precisely this population, the frail elderly, who are most in need of long term care services in general and institutional or nursing home services in particular. In the 65 years or older population group, only 5 percent are in nursing homes. For those who are 85 years or older, however, almost 25 percent reside in nursing homes.

The implications of this growth for the long term care industry are astounding. There are currently 1.5 million nursing home beds in the United States. Assuming the proportion of elderly residents to total nursing home beds remains constant over the next 20 years, there is a projected need for an additional 587,000 nursing home

beds by 1990 and 1.2 million beds by the year 2,000. In other words, within the next two decades the country will have to almost double its supply of nursing home beds.

Currently the nursing home industry is experiencing an annual growth rate of one percent; this figure should be three and one-half percent if we are to keep pace with current demand. This projected growth in demand is conservative at best. It does not, for example, take account of the likely implications of the new Medicare prospective payment system for hospital services. With a system based now on one payment for an entire length of stay in a hospital, rather than on a per diem approach, acute care facilities will have every incentive to move their patients into a long term care setting at the earliest practicable opportunity. This will produce even greater demands for institutional long term care services.

### II. CAPITAL NEEDS OF LONG-TERM CARE

Given the historical nature of the long term care industry, it is only the proprietary or investor-owned segment of the industry that will be able to meet the projected demand for services. Indeed, in recent years only the investor-owned segment has added beds. An increase of 77,000 new investor-owned beds during the year 1973–1977 compares to a decline of 1,000 beds in non-profit institutions and a decline of 2,000 beds in governmental-owned institutions during that same period.

Translated into capital requirements, some $58 billion will be required by the year 2000 to meet the need for new beds alone. This is a conservative figure that does not take into account the additional funds needed for upgrading old facilities. Given historical precedents, it is unlikely the voluntary and non-profit segment of the industry will be able to meet more than an infinitesimal portion of these capital requirements. Only the investor-owned industry will be in a position to meet the needs of the American population for long term care services.

In contrast to hospitals, which are overbedded, our occupancy rates are 95 percent or better. The critical nursing home bed need in most States is best illustrated by the tremendous backlog of patients in hospitals awaiting nursing home beds. A figure as high as $1.5 billion has been estimated as the annual cost of this backlog to Medicare and Medicaid.

Yet a number of States persist in preventing any new construction of nursing home beds through moratoria on certificates of need. They believe that they can save on new Medicaid expenditures if the beds are not available to be filled. This policy is obviously short-sighted as patients merely use the hospital setting for their long term stays at four times the cost.

Another sharp contrast between hospitals and nursing homes is that our industry is a relatively new one, with many of the proprietary facilities built during the last 15 years. This means not only that our capital costs are relatively higher, since our per diem rates are only in the $40–$50 range, but also that the capital costs as a percentage of those rates are proportionately higher. Still it costs only $2.5–$3 million to build a 125-bed nursing home, or about $25,000–$30,000 per bed.

### III. NEED FOR SMALL ISSUE INDUSTRIAL DEVELOPMENT BONDS

With the critical nursing home bed need described earlier, the issue of capital formation becomes paramount. During the last ten years, as interest rates have escalated, the investor-owned industry has come to rely almost totally on small issue industrial development bonds (IDBs) for financing of new construction. It is with no little consternation that we see the Congress act to sunset small issue IDBs by January 1, 1987, and to seek further restrictions on IDBs in this session of Congress. We urge members of your Committee to take no action that would further restrict the availability of small issue development bonds for nursing home construction.

Of particular concern are proposals that would limit the outstanding IDB debt to $40 million per company and impose a statewide per capita volume cap on all issues. We are confident that these two provisions alone will put an effective halt to nursing home construction in this country.

First, it is only the multifacility nursing home firms that are engaged in any significant construction; this provision would automatically exclude them from any further building if their current IDB debt exceeds this figure. Second, a $40 million cap is irrelevant and would result in no savings if a state volume cap is also in place. Third, under the state volume cap nursing homes not only would have to compete for IDBs, they first would have to obtain a certificate of need within the state, a lengthy and burdensome process that none of the other competing bodies would have to go through.

It would seem that Congress and the states are placing so many obstacles in the way of nursing home construction that, at least by default, their public policy objectives are to halt any new nursing home construction.

### IV. INVESTOR-OWNED VERSUS NOT-FOR-PROFIT NURSING HOMES

As we have shown, the investor-owned segment is the largest and the only growing segment of the nursing home industry. In addition, the proprietaries have done more than their fair share in dealing with the long term care needs of America's indigent population. Indeed 57 percent of residents in the investor-owned nursing homes are indigent while the comparable statistic for tax-exempt or not-for-profit nursing homes is 44 percent.

Not only do the investor-owned nursing homes serve a higher proportion of Medicaid patients, they also provide services at a lower cost. According to 1983 data from the Health Care Financing Administration, investor-owned nursing home averaged $68.30 per day total costs (including capital) for Medicare SNF care. The comparable figure for nonprofit homes was $103.80; and for government facilities, $92.45; and for hospital-based SNFs, $131.51.

Notwithstanding the proprietaries' higher proportion of Medicaid patients and lower costs, it is the tax-exempt segment of the industry that is considered "public purpose" and thus continues to have access to lower cost financing through industrial development bonds. It is this kind of misdirected public policy that has led to the financial difficulties of the Medicare and Medicaid programs today. Higher cost facilities are being subsidized while the more efficient investor-owned nursing homes will be forced to go to the marketplace for higher financing costs which then will be translated into higher Medicare and Medicaid costs.

### V. EFFECT OF PROPOSALS TO LIMIT CAPTIAL COSTS

Even though Medicare revenues make up only two percent of nursing homes' income, the treatment of capital under the program is critical because many state Medicaid programs apply Medicare principles in their reimbursement methodologies.

If, as experts have pointed out, we are going to need 1.2 million new nursing home beds by the end of this century, a fair and equitable amount for capital must be recognizd in the rate. No lending institution will wish to invest in an industry in which real costs of capital are frozen at an unrealistic standard or are not recognized at all.

The inadequacies of the present reimbursement system are apparent if one realizes that it has become more advantageous for many nursing home owners to sell than to remain in operation. The system provides no incentives for economies or efficiencies of operating and no profit, save for a return on owners' net equity.

The solution for bad system, however, is not to make it worse. The Department of Health and Human Services Office of Inspector General has lauded systems such as the one currently in place in New York State, which does not recognize appreciation in property costs on resale. We suggest that there are other states to which one should look for models to be emulated, such as Maryland or West Virginia, but not New York. The former states have demonstrated that it is possible to institute equitable systems of capital reimbursement, such as fair rental values, without practicing confiscatory policies.

To advocate, as the Inspector General has done, a system such as New York's would be tantamount to putting a halt to all new nursing home construction. Enormous backlogs of patients in hospitals awaiting nonexistent nursing home beds would result, just as we see occurring in that state today.

Ten years ago, in its extensive study of the nursing home industry, the New York State Moreland Commission recommended a fair rental system for payment of capital costs, however, it would seem that its recommendations were ignored. The Commission recognized the dangers of a system that fails to recognize legitimate capital costs of providers, stating:

"It would be unwise public policy to court the risk that, as a result of low reimbursement, nursing home property would be converted increasingly to other uses."

We suggest this is precisely what will happen if a provider is unable to sell his property for its fair market value with the result that nursing home patients will be dislocated and the shortage of beds will grow.

Any freeze of property values or failure to recognize appreciation will have a three-fold negative impact: (1) nursing homes will not be built because financing will be unavailable, (2) owners will not expand in a market that does not recognize their costs, and (3) providers already participating in the program will seek other

uses for their property that allow the opportunity for a fair return on their investment.

### VI. PROSPECTIVE PAYMENT FOR MEDICARE SKILLED CARE

The investor-owned nursing home industry has been advocating a prospective payment system for Medicare for many years. Within the last year, the National Council of Health Centers and the American Health Care Association commissioned a study conducted by Dave Bishop, CPA, and Frank Sloan, Ph.D., to determine the feasibility of a case-mix payment system predicated on the resource allocation of services by patient and condition. We firmly believe that a payment system that would focus on patient needs, not individual facility characteristics, will be the most appropriate, while resolving many of the current problems of access and backlogs. It is essential that the issue of capital be discussed in tandem with a prospective payment system and not prematurely without due consideration of the impact it would have. An ideal system would establish a rate that includes capital costs but obviates the need for consideration of each individual component of capital. We urge interested members of Congress to recognize the inherent differences between hospitals and nursing homes and not to take actions that would adversely affect the limited expansion taking place in the nursing home industry today.

### VII. SUMMARY

We ask that you (1) take no action to further restrict the availability of industrial development bonds for nursing home construction and (2) do nothing to affect the treatment of capital under Medicare for nursing homes. Rather, this subject should be dealt with at the time a prospective payment system is developed and implemented for skilled nursing facility care. It is vital that the small amount of growth occurring in long term care today not be curtailed by precipitous actions by the Congress.

APPENDIX 1

Average Facility Costs, By Type of Ownership

Proprietary Homes

| | Unweighted | | Weighted By Medicare Days | | Weighted By Total Days | |
|---|---|---|---|---|---|---|
| | Mean | S.D. | Mean | S.D. | Mean | S.D. |
| Routine Operating | 43.46 | 13.51 | 47.96 | 29.73 | 42.60 | 21.98 |
| Routine Nursing | 17.99 | 6.23 | 19.78 | 13.05 | 17.44 | 9.62 |
| Routine Overhead | 25.47 | 8.19 | 28.18 | 18.04 | 25.16 | 13.54 |
| Medicare Ancillary | 12.23 | 8.47 | 15.62 | 17.69 | 11.35 | 13.59 |
| Drugs and Supplies | 5.72 | 5.12 | 7.09 | 8.60 | 5.27 | 8.39 |
| Therapies | 6.51 | 6.40 | 8.53 | 13.87 | 6.08 | 10.59 |
| Capital Costs | 4.10 | 2.48 | 4.73 | 4.84 | 4.00 | 3.93 |
| Total Costs | 59.79 | 18.87 | 68.30 | 44.07 | 59.95 | 28.83 |
| Nonprofit Homes | | | | | | |
| Routine Operating | 62.80 | 27.64 | 76.01 | 58.69 | 60.98 | 36.70 |
| Routine Nursing | 24.82 | 11.05 | 30.19 | 23.26 | 23.63 | 14.45 |
| Routine Overhead | 37.98 | 17.94 | 45.82 | 38.03 | 37.36 | 26.94 |
| Medicare Ancillary | 14.68 | 15.82 | 21.86 | 35.80 | 11.30 | 21.54 |
| Drugs and Supplies | 5.75 | 6.76 | 6.98 | 11.51 | 4.41 | 10.74 |
| Therapies | 8.93 | 12.56 | 14.89 | 29.76 | 6.89 | 16.73 |
| Capital Costs | 4.61 | 4.18 | 5.92 | 8.53 | 4.39 | 5.49 |
| Total Costs | 82.09 | 41.00 | 103.80 | 89.13 | 76.67 | 51.66 |
| Government Homes | | | | | | |
| Routine Operating | 65.94 | 24.77 | 74.40 | 43.74 | 68.08 | 46.14 |
| Routine Nursing | 25.20 | 19.43 | 27.98 | 16.51 | 25.20 | 14.76 |
| Routine Overhead | 40.73 | 16.86 | 46.42 | 29.35 | 42.88 | 33.60 |
| Medicare Ancillary | 13.11 | 13.20 | 14.87 | 22.47 | 10.22 | 23.85 |
| Drugs and Supplies | 5.34 | 5.46 | 5.19 | 9.26 | 3.21 | 9.80 |
| Therapies | 7.77 | 10.32 | 9.67 | 18.09 | 7.01 | 20.23 |
| Capital Costs | 3.14 | 2.72 | 3.18 | 3.95 | 2.99 | 4.74 |
| Total Costs | 82.19 | 33.90 | 92.45 | 59.63 | 81.29 | 60.35 |

Source: Medicaid Skilled Nursing Facility Data, Table 16 HCFA, June 1983.

APPENDIX 2

Average Facility Costs
By Type of Facility

Free-Standing

| | Unweighted | | Weighted by Medicare Days | | Weighted by Total Days | |
|---|---|---|---|---|---|---|
| | Mean | S.D. | Mean | S.D. | Mean | S.D. |
| Routine Operating | 45.76 | 14.30 | 48.37 | 24.29 | 47.51 | 30.24 |
| Routine Nursing | 18.77 | 6.16 | 19.86 | 10.60 | 19.03 | 11.36 |
| Routine Overhead | 26.99 | 9.24 | 28.50 | 15.44 | 28.48 | 20.28 |
| Medicare Ancillary | 11.39 | 3.98 | 14.12 | 15.28 | 11.33 | 14.55 |
| Drugs and Supplies | 5.26 | 5.14 | 6.58 | 8.50 | 4.62 | 8.95 |
| Therapy | 6.13 | 6.28 | 7.54 | 11.09 | 5.71 | 11.09 |
| Capital Costs | 3.98 | 2.49 | 4.46 | 4.27 | 3.96 | 4.40 |
| Total Costs | 61.12 | 18.01 | 66.95 | 32.63 | 61.80 | 34.32 |

Hospital-Based

| | Unweighted | | Weighted by Medicare Days | | Weighted by Total Days | |
|---|---|---|---|---|---|---|
| | Mean | S.D. | Mean | S.D. | Mean | S.D. |
| Routine Operating | 77.88 | 33.40 | 94.98 | 65.97 | 74.49 | 40.38 |
| Routine Nursing | 29.86 | 13.95 | 36.85 | 27.69 | 27.74 | 15.32 |
| Routine Overhead | 48.01 | 21.14 | 58.14 | 42.31 | 46.75 | 27.07 |
| Medicare Ancillary | 22.32 | 19.16 | 29.75 | 44.63 | 19.18 | 24.87 |
| Drugs and Supplies | 8.37 | 7.80 | 8.18 | 13.85 | 6.53 | 10.46 |
| Therapy | 13.95 | 15.91 | 21.57 | 37.94 | 12.64 | 21.18 |
| Capital Costs | 5.11 | 5.12 | 6.78 | 11.41 | 4.10 | 4.97 |
| Total Costs | 105.31 | 50.05 | 131.51 | 2.70 | 97.76 | 58.21 |

Source: Medicaid Skilled Nursing Facility Data, Table 17 HCFA, June 1983.

LOS ANGELES, CALIF., *March 7, 1984.*

Hon. WILLIS D. GRADISON, Jr.,
*House of Representatives,*
*Washington, D.C.*

DEAR MR. GRADISON: This correspondence is in reference to hospital mergers and the provision of Medicare and Medicaid payments thereof, in regards to capital costs. The issue concerns the increase in Medicare and Medicaid payments created by a change in hospital ownership. The specific complaint is that this increase contains a significant portion of excessive and inappropriate funding. Unfortunately, this situation is perpetuated by flagrant compliance and enforcement of designated regulations and guidelines pertaining to existing Medicare and Medicaid statutes.

Hospital Corporation of America, in its official proxy statement dated July 10, 1981, which was distributed to the stockholders and filed with the Securities and Exchange Commission, estimated that additional reimbursement from Medicare and certain other cost-based reimbursement plans was approximately $32 million annually as a result of the acquisition of H.A.I. (see H.C.A. Proxy Statement for August 14, 1981). Based on the General Accounting Office's findings and other issues discussed in this letter, it appears that this estimate is in excess of the amount allowable under current Medicare regulations and instructions by about $15 million.

During the past three years, there has been a spate of acquisitions of hospitals at prices well above the cost of construction. The Federation of American Hospitals Directory of investor owned hospitals shows that hospitals owned by investor owned companies increased from 420 hospitals with 58,357 beds in 1977 to 668 hospitals with 89,171 beds in 1982 (see 1983 Directory, Federation of American Hospitals). These statistics do not reflect the several mergers that have taken place during the period or the acquisition of nursing homes. This significant increase and the bidding wars that have taken place indicate a trend towards increased competition for certain hospital properties and the premium prices being paid for potential future earnings or "goodwill". Reflecting goodwill in the balance sheet of a company results in reduced Medicare reimbursement and tax benefits, while affecting the company's ability to raise money in the capital markets. Consequently, a major economic incentive to understate goodwill and overstate the value of the tangible assets that are acquired, exists.

If the capital costs claimed as a result of these acquisitions made in the past few years are reviewed for compliance with the existing regulations, *tens of millions and probably over one-hundred million dollars can be saved for the Medicare trust fund.* The Medicare statute of limitations does not preclude such a review for 3 years from the date of final settlement of the cost report.

The reasons for the overpayment from the Medicare trust fund are as follows:

Valuations submitted in support of the "stepped up" values of assets by appraisal companies are in most instances accepted without critical review by the fiscal intermediaries who are responsible for the audit of the Medicare cost reports. The intermediaries lack the expertise or the resources to ensure that the valuations are in compliance with the Medicare regulations.

The appraisal companies that are retained by the Medicare providers to perform these valuations are often not independent. The General Accounting Office, based on their review of the appraisals submitted by Hospital Corporation of America, questioned the independence of the appraisals. Appraisal companies are under pressure to assign a high value to the tangible assets acquired and to minimize or eliminate goodwill. If the appraisal companies do not cooperate they risk not being retained. Appraisal companies that do cooperate, are typically retained. Major chains, because of the large number of acquisitions that they make each year and the business they have to offer to appraisal companies, are able to exert great pressure on appraisal companies. To support this contention, all that needs to be done is to examine the valuation of hospitals that have changed hands several times in the last few years. As the premium price paid for these properties has escalated, appraisal companies have become more and more "creative" in assigning values to tangible assets using methods which are not in accordance with the Medicare regulations and instructions.

In its report, GAO observed that for the H.A.I. hospitals acquired by H.C.A., economic life of 50 years for both hospital buildings and building services equipment was used to determine depreciated reproduction costs. The American Hospital Association useful lives guidelines which have to be used unless an exception is granted by the intermediary, show a maximum useful life of 40 years for building and 10 to 20 years for building services equipment. The G.A.O. found that H.C.A.'s method substantially increased depreciated reproduction costs compared with those that

would have been computed using A.H.A. useful life guidelines. This also resulted in a significantly higher claim for Medicare reimbursement than that permitted by the regulations. It is pertinent to note that these assets were depreciated by H.A.I. using composite lives as low as 25–30 years prior to the sale.

Medicare regulations require that the cost basis for the depreciable assets of a facility acquired as a going concern, in a bona fide sale after August 1, 1970, is limited to the lowest of the following: (1) Current reproduction cost of the assets depreciated on a straight line basis over their useful life to the date of sale; (2) Price paid by the purchaser; or (3) Fair market value of the facility as of the date of the sale.

In the G.A.O. report on the Hospital Corporation of America's acquisition of H.A.I., no reference is made as to how (1) the price paid by the purchaser for the facility, or (2) the fair market value of the facility was determined. This has a major impact on Medicare reimbursement for capital costs, since in several instances the price paid or the fair market value can be lower than the reproduction cost. A review of the undermentioned transactions clearly illustrates this point.

| Typed of hospital | Date of transaction | Service area | Price per bed | Purchase price as a percent of asset book value |
|---|---|---|---|---|
| Acute care | 1983 | Affluent suburban | $175,000 | 177 |
| Acute care | 1983 | Inner city urban | 78,000 | 78 |

The hospital in the affluent suburban area was purchased at 177% of the book value at $175,000 per bed, which is far in excess of the reproduction costs, whereas the inner city hospital was purchased at 78% of its book value or $78,000 per bed, below its reproduction cost. This is primarily due to the inner city hospital being high *cost* based (Medicare/Medicaid) and less profitable than the suburban hospital, which has a higher private insurance *charge* based patient load.

In a multiple facility purchase, as in the case of H.C.A.'s acquisition of H.A.I., the total purchase price should be allocated to all the facilities based on their fair market value as of the date of sale. The fair market value, the amount a knowledgeable buyer should be willing to pay, is a function of four factors: the expected return of the assets, the timing of the return, the certainty of the return, and the return offered by other similar investment opportunities.

The method used by H.C.A. to allocate the purchase price was the current depreciated reproduction cost for the assets of the facility. This method is clearly inappropriate as in the example cited above, both the inner city hospital and the suburban hospital will have the same value per bed assigned although the prices differ significantly.

The method used by H.C.A. results in substantially increased reimbursement of capital costs for high Medicare/Medicaid hospitals which were incurring losses or experiencing marginal returns. This is contrary to the Medicare program policy.

Medicare intermediaries assume the position that the price paid by the purchaser is the same as the fair market value of the assets. The following excerpt from a recent article by an expert in acquisition and mergers contradicts this position (See Attachment I): "The potential buyer is no doubt aware of the extraordinary range in hospital values. In the past four years, sale prices for hospitals have ranged from $10,000 per bed to more than $300,000 per bed, with a mean of $96,000 and a standard deviation of just less than $50,000. Financially justifiable differences in value result from market differences in these areas: service demographics (see Table I on page 31), regulatory environments, utilization trends and market growth (to name but a few determinants of value). However, situations routinely arise where the price paid demonstrates a lack of financial sophistication on either the buyer's or the seller's part. In some cases a lack of understanding regarding the current pricing mechanism at work in the health care industry accentuates the market differences and helps to produce the even wider differences in hospital values."

The methods conventionally used to determine fair market value are:

*(i) Cost summation approach.*—In this method fair market value of the land is estimated as if vacant. To that figure is added depreciated reproduction cost of the building and land improvements. Depreciation is calculated on an age/life basis which reflects effective age, remaining economic life, physical deterioration, functional and economic obsolescence.

*(ii) Market analysis approach.*—The comparative procedure is to obtain the sale price of similar facilities, usually expressed in terms of price per bed.

*(iii) Income approach.*—The fair value of the facility based upon its value as a continuing operation as of the date of sale is estimated. This approach is generally used to estimate the income potential of the hospital over the life of the existing facility and discount the income stream at an appropriate rate.

The fair market value should be estimated in order that the cost basis of the facility can be determined in accordance with the Medicare regulations.

A multi-hospital chain organization has a choice of either reflecting the capital debt and interest in the "Home Office Cost Report", which is a separate cost report filed for corporate transactions, or reflecting it in the individual facility's cost report. Several methods of "gaming" through the Home Office Cost Report are available that could significantly increase Medicare reimbursement. These methods are in general contrary to the Medicare regulations. They occur primarily because of the complexity of the transactions that take place at the corporate level, compounded by the lack of clear instructions by H.C.F.A.

The independence of the fiscal intermediary is impaired by the ability of the providers to request a change of intermediary when a change of ownership occurs. H.C.F.A. has granted such requests in one instance when highly contentious reimbursement issues were involved (see Attachment II). When such changes are granted, intermediaries are faced with the problem of layoffs.

Some of the intermediaries such as private insurance companies that are now being frequently selected by the proprietary hospital chains have investments in these chains.

As a result of the acquisition of H.A.I. by H.C.A., I.N.A. became the principal stockholder of H.C.A., owning 10.4% of the outstanding common stock of the company. At that point no other person, group or entity owned as much as five per cent of the outstanding common stock of the company (see H.C.A. Proxy Statement for August 14, 1981).

Under 42 CFR 405.421 Medicare's related organization rule, if two parties are considered related then no step-up in the value of assets is permitted. In a recent decision the Provider Reimbursement Review Board held that a provider that had 28% interest in the initial capitalization of a laundry and 14.2% in the current capitalization had a "significant" ownership interest in the laundry and was therefore deemed related to the laundry (see PRRB Decision No. 84-D10, Madison General Hospital). In this case the Board stated that the ability to control existed, and whether or not control existed was irrelevant. In Medical Center of Independence vs. Harris, the U.S. 8th Circuit Court stated that the Medicare related organization rule applied even if control may not have existed during the negotiating stage.

In its report the G.A.O. does not address the question of whether HCFA examined the transaction for the applicability of related organization rule. If this rule was applicable and step-up of the assets was not permitted, substantial savings would accrue to the Medicare trust fund. It is, therefore, essential to ensure that HCFA and the intermediary have reviewed this merger for the applicability of the related organization rule.

In addition to the above Medicare reimbursement considerations, the following issues relating to acquisition and mergers should be addressed:

There is considerable evidence that asset valuations for tax purposes are also overstated. This results in substantial loss in tax revenues.

There is also evidence that public offerings are made of stocks and other securities based on inflated estimates of increased Medicare payments for capital costs as a result of step-up in the value of assets.

The existing S.E.C. and accounting rules permit hospital management companies to manipulate their earnings. An estimated 50% of the income of hospitals is received from Medicare/Medicaid. If the estimate of the income from Medicare/Medicaid is substantially overstated in one year, the loss could be written off in a subsequent year and reflected as the *current year* transaction in that year. In other industries the financial statements of the year in which the incorrect estimate was made would have to be restated or the write offs reflected as a prior year adjustment.

I understand the hearing on March 21st will focus primarily on legislative changes to correct this problem. May I also urge you to ensure that steps are taken to recover amounts inappropriately paid out which could exceed $100 million.

I will be prepared to testify as a public witness on the issues addressed in this letter. I have over ten years of experience in the health care industry and more than five years' experience in a fiscal intermediary capacity. At the time of the acquisition of H.A.I. by H.C.A. I held the position of Director of Reimbursement Appeals at H.A.I.

Finally, may I commend you on your efforts at highlighting this issue, which has resulted in the inappropriate application of Medicare trust funds.

Sincerely,

J. C. RAVINDRAN.

Attachments.

ATTACHMENT I

# What's a hospital worth?

**In light of recent fluctuations in hospital prices, a methodology based on the Nuveen Valuation Model helps separate fact from fiction.**

by Judson Bergman

*"The greatest gift is the ability to estimate correctly the value of things."* La Rochefoucauld, seventeenth-century French philosopher.

Confronted by enormous capital requirements for the renovation or replacement of their assets, a deterioration of third-party payment levels, rapidly evolving medical technology, and changing demand for services, many hospitals are choosing to consolidate to deal better with industry pressures. This industry consolidation has been expedited by capital markets eager to finance the investor-owned systems' expansion. Thus, with the emergence of well-capitalized and aggressive buyers, more and more communities are considering selling their local hospitals outright.

For sellers and buyers alike, determining the market value of a given institution is a difficult problem. A buyer's estimation is at times based on the buyer's purchasing power – what it can afford – rather than on the expected return offered by the hospital's assets. Other buyers routinely determine value from some mandatory multiple of earnings. Accordingly, valuation procedures are far from being uniform and often contain errors. Tested financial principles are of fundamental importance in understanding the intrinsic market value of a hospital and, as such, are the framework for the Nuveen Valuation Model.

The potential buyer is no doubt aware of the extraordinary range in hospital values. In the past four years, sale prices for hospitals have ranged from $10,000 per bed to more than $300,000 per bed, with a mean of $96,000 and a standard deviation of just less than $50,000. Financially justifiable differences in value result from market differences in these areas: service area demographics (See table 1 on page 31), regulatory environments, utilization trends, and market growth (to name but a few determinants of value). However, situations routinely arise where the price paid demonstrates a lack of financial sophistication, on either the buyer's or the seller's part. In some cases, a lack of understanding regarding the current pricing mechanism at work in the health care industry accentuates the market differences and helps to produce the even wider differences in hospital values.

Market value, the amount a knowledgeable buyer should be willing to pay, is a function of four factors: the expected return of the assets, the timing of the return, the certainty of the return, and the return offered by other similar investment opportunities. The difficulty in any evaluation is the correct application of these factors.

Nuveen's valuation model is based on a hospital's ability to generate a return measured by its free cash flow* – the cash available for disbursement to

*Judson Bergman is an associate with John Nuveen and Co. Inc., Chicago.*

**Free cash flow equals cash generated less investment necessary to enhance the hospital's assets and improve services. This investment averages $3,000 to $6,000 per bed per year. For a more detailed calculation, see box entitled "Determining Free Cash Flow," page 31.*

both debt holder and owner over time. By evaluating cash flows to both debt and equity holders, the market value of the *total* assets is determined, not the value of the equity or net assets. The future free cash flows are discounted back to the present (using an asset risk factor to establish the correct discount rate) to determine the present value of the assets.

Once the hospital's free cash flow is determined, the model divides this return according to revenue sources and values each according to its degree of financial and business risk (to be discussed later).

Beyond the value associated with free cash flow, the buyer of assets often ascribes economic value to an institution for strategic purposes, such as the protection of market share from a competing system or for opportunities to enter a new market. However, such values are difficult to anticipate because there is no objective yardstick by which to measure them and especially because strategic value is so highly relative to each buyer. It should also be pointed out that the return generated by a hospital's assets need not be economic for it to affect value. The ability of a local government to provide jobs through its hospital, for instance, may be a perceived valuable return for the county or city, although it is difficult to quantify.

The correct measurement and timing of expected return generally do not pose great difficulty for either the buyer or the seller, perhaps because corporations in other industries have long used similar methods to measure return in their investment decisions.

The correct measurement of risk, however, is more difficult to achieve, yet it is essential to the accurate measurement of the likelihood of the return. A multi should understand the two overriding components of risk because each affects value. Financial risk is a function of the degree of financial leverage the hospital requires in its operations. The greater the leverage, the greater the risk of receipt of the equity cash flow (because cash flow accrues to the equity holder only after debt has been serviced), and the higher the necessary discount rate that must be applied to the equity cash flow. The second risk is the hospital's business risk. This is a

## Determining free cash flow

For information content and as a starting point in determining the free cash flow, hospital earnings compare favorably to the earnings of other industries. This is because hospital earnings are not subject to manipulation from liberal revenue recognition policies, health care payers are creditworthy, and expense measurements (cost of services, inventory costs, and the like) are less vulnerable to material accounting policy changes that affect earnings.

To determine the free cash flow, the necessary adjustments to earnings are a straightforward process. For the not-for-profit hospital, they are as follows:

Earnings
+ Interest expense
+ Noncash expenses
= Cash flow generated from operations
− Investment or incremental increase in net assets (for example, working capital, equipment, or land)
= Free cash flow

Because the investor-owned hospital has the additional consideration of taxes, it is necessary to adjust for its tax advantages of debt by using the hospital's after-tax cost of debt to determine an appropriate discount rate. The procedure is as follows:

Earnings before interest, after tax (Calculate taxes as if no interest payments are made.)
+ Noncash expenses
= Cash flow generated from operations
− Incremental increase in net assets
= Free cash flow

Beginning October 1986, interest and depreciation expenses will cease to be "pass-through" expenses under the new Medicare prospective pricing system. Consequently, successful valuations will not project an expected return where capital costs exceed a fixed percentage (perhaps seven percent) of operating expenses. This important development in the capital reimbursement area will have an adverse effect on hospital market value. □

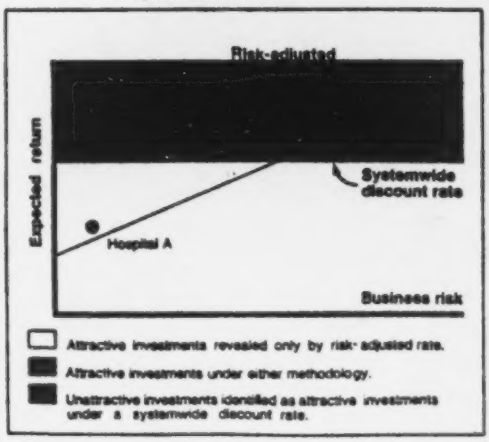
**Recent purchases of hospital assets reported**

| Type of hospital | Date of transaction | Service area | Price per bed | Purchase price as a % of asset book value |
|---|---|---|---|---|
| Acute care | 1983 | Affluent, suburban | $175,000 | 177% |
| Acute care | 1983 | Inner-city, urban | $ 78,000 | 78% |

function of many factors, including market demographics, utilization and trends, and payer mix.

Until recently, the buyer's cost of capital has been regarded as probably the most important element in establishing an appropriate measure of risk, or discount rate, the rationale being that the cost of funds determines the value of investments. Unfortunately, a buyer can ascribe more value to assets than justified if its cost of capital is lower than the seller's. In such a case, the discount rate is too low, and, consequently, the capitalized value of projected cash flows is too high. Although the buyer's cost of capital is one important consideration, it is the selling hospital's cost of capital that is a more accurate estimate of the appropriate discount rate, because the selling hospital's cost of capital is a better indication of the underlying asset's business risk.

For example, if an AA-rated system that enjoys low-cost financing uses its own cost of capital as a discount or hurdle rate, the system's discount rate will ascribe more value than merited to institutions of below AA credit. Because the system does not require higher return for increased risk but instead uses its own lower-risk cost of capital to establish purchase prices, the system will jeopardize its own credit standing. Only if the buyer can change the business risk of the seller's assets to match its own more closely (for example, through superior management, lower material or labor costs, or a significantly improved relationship with physicians) is its own cost of capital the more correct rate. By risk-adjusting the discount rate, however, the system can grow through acquisition of institutions of less strength and not jeopardize its own standing. Conversely, if the seller is of greater financial and business strength than the buyer, the AA-rated system can use a discount rate *lower* than that determined by its own assets.


Risk-adjusted
Expected return
Systemwide discount rate
Hospital A
Business risk
Attractive investments revealed only by risk-adjusted rate.
Attractive investments under either methodology.
Unattractive investments identified as attractive investments under a systemwide discount rate.

As illustrated in the figure on this page, successful valuations require a risk-adjusted discount rate. A single discount rate would result in accepting high-risk hospital C and rejecting low-risk hospital A. A risk-adjusted discount rate reveals the better investments. Accordingly, hospital A is a superior investment, while C offers insufficient return for its risk. Hospital B, meanwhile, demonstrates a hospital that is attractive under either valuation methodology. A risk-adjusted rate demands higher return for increased asset risk.

In the event an investor-owned system is evaluating a not-for-profit hospital, the cost of capital for the hospital as an investor-owned institution should be established. Likewise, a not-for-profit system purchasing an investor-owned hospital should estimate the seller's likely tax-exempt cost of capital.

One problem that arises, however, is that many selling hospitals have no debt or equity outstanding, and determining their cost of equity or cost of fund balances becomes a difficult problem. Often, investor-owned systems estimate the seller's cost of equity from the stock market's capitalization of their own earnings and use this estimated cost of equity to value the after-interest expense cash flows of a potential acquisition. But suppose the buyer is a not-for-profit system, which has no market to provide it with equity funds. Although it has no equity market, it does have equity or fund balances arising from retained earnings, gifts, and grants. A capital cost for these fund balances must be determined.

To measure a hospital's business risk and establish the correct discount rate, the Nuveen model incorporates a risk factor that adjusts a company's discount rate by evaluating an array of considerations, many of which do not affect cash flow directly. Although most acquiring multis realize that noncash flow considerations are important, they do not always incorporate the noncash flow considerations systematically. In developing its model, Nuveen isolated six measures that explain more than 80 percent of the variance in asset market value:

- Demographics of the service area
- Historic utilization
- Cost-based reimbursement
- Market share
- Historic operating margin
- Degree of regulation (including rate review).

The hospital that compares favorably to others in the above considerations will experience in all likelihood greater profitability, less variation in cash flow, lower business risk, and higher value. (See box entitled "Determinants of Business Risk" on page 33 for a more detailed list.)

One important aspect of a hospital's value is its

ability to generate returns on capital in excess of its cost of capital. This positive spread is known as "economic rents." Theoretically, when economic rents appear, competition intensifies, and the spread inevitably disappears so that the company's return in a competitive economy equals its cost of capital. What distinguishes the health care industry from others, and why buyers pay premiums over replacement costs, is that the normally evanescent economic rents are legislatively protected because additional competition is regulated by many localities. As a result, the profitable hospital has a partially regulated monopoly on its cash-flow generating power.

A terminal value, or the present value of all future cash flows past the individually projected years, should reflect a hospital's ability to generate economic rents. To value this excess return, Nuveen uses a methodology similar to that developed by Stanford University's John G. MacDonald. The methodology first values the assets from the perspective that they will yield returns only equal to the cost of capital and then adds the incremental premium to the excess cash flow. When correctly considered, these rents are an important component of value, and can justify many of the current premiums being paid for hospitals.

Other methodologies for evaluating the terminal value are routinely used. Some buyers estimate market value by using a multiple of projected book value based on current multiples of book value for the industry. Other techniques use a simple multiple of earnings, with a lower multiple signifying greater risk.

Once a value has been determined from the hospital's ability to generate free cash flow, the result can be compared with the "yardstick" provided by the capital markets. Industrywide benchmarks can be found by using the market value of the right-hand-side items of the balance sheet (liabilities and equity) as a proxy for the current market value of the assets. First, the current value of outstanding common stock is calculated as the product of the current stock price and the total common shares outstanding. Next, the current market value of outstanding long-term debt is estimated, and the book value of current liabilities is determined.

The three items are added, and from this sum cash is subtracted. The difference is then divided by the total number of beds in the system to yield an asset price per bed that is comparable across the industry for large investor-owned systems.

An example of the mechanics of this comparative benchmark is found in table 3 on page 34 for Humana, which currently has 79,845,874 shares outstanding. Given the 18,362 beds controlled or under development by Humana, this yields an asset market value range of between $208,000 and $217,000 per bed. Humana's market value has been affected positively by management's ability to continue earnings growth through a highly successful acquisition program. The comparative data listed in the tables on the next page for Humana and Evangelical Health Systems illustrate the wide difference between book value and market value for an investor-owned system and identify the book value per bed of a leading midwestern not-for-profit system.

This article has discussed the key determinants of value in the Nuveen model in order to examine the causes of the wide range in market values for hospitals. Because the business risks vary significantly among hospitals, much of the discussion has focused on these risks. Also identified was one methodology to measure the return offered by the assets. Health care is a technology- and capital-intensive industry. Therefore, in measuring the return, note that value will be affected by the amount of capital investment in the assets. For example, an older plant will need greater year-to-year investment and thus bear a smaller market value than will a new one.

The timing of the return is one determinant of value that was not discussed directly. When using a

## Determinants of Business Risk

- What is the age and quality of the existing plant?
- What is the economic strength of the service area? The unemployment rate? Is it a service economy? Industrial? Manufacturing? What growth rates are forecast?
- Can the hospital price its services competitively?
- What are the historic occupancy rates?
- Is there mandatory rate review in the area?
- What are the income demographics of the service area?
- What population trends are expected?
- Is entry into the market regulated?
- What is the size of the service area?
- Are there competing hospitals in the area?
- What is the hospital's market share?
- How stable is the market?
- What is the dispersion of the market?
- What is the quality of the medical staff?
- What is the quality of the executive staff?
- How well does the hospital know its market's purchasing cycles and patterns?
- What is the hospital's proximity to doctors' offices?
- Do operating expenses compare favorably with competing hospitals' expenses?
- Have previous budgets been reliable?

Table 2
**Book value: Evangelical Health Systems (In $thousands, except per bed data)**

| | Book value* |
|---|---|
| Fund balances | $ 94,262 |
| Debt | 86,880 |
| Current liabilities | 31,629 |
| Total asset value | 212,800 |
| Book value per bed | 130,742 |

* As of 12/31/82
Source: Evangelical Health Systems 1982 annual report.

discounted cash flow approach to determine value, reasonable projections of when the return will occur are important.

Finally, by undertaking an analysis that follows the principles outlined here, a hospital or system can begin to understand its relative strengths and weaknesses and thus be better able to examine the economics of operating a hospital in the 1980s. □

Table 3
**Book and market value: Humana, Inc. (In $thousands, except per-bed data)**

| | Book value* | Market value range |
|---|---|---|
| Common stock (recent trading range $34-36) | $ 608,426 | $2,713,887-2,873,527 |
| Preferred stock | 60,556 | 55,712-68,134 |
| Debt | 1,056,470 | 1,004,985-1,011,000 |
| Current liabilities | 299,000 | 287,040 |
| Less: Cash | (250,000) | (250,000) |
| Total asset value | 1,774,452 | 3,811,624-3,979,701 |
| Per-bed value | 96,637 | 208,000-217,000 |

* As of 6/31/83
Source: Standard NYSE Stock Reports (Standard & Poor's Corp.) and Humana, Inc.

ATTACHMENT II

Los Angeles Times

*Coercion Charged*

# Hospital Corp. Named in Bid-Tampering Suit

By JOHN L. MITCHELL, *Times Staff Writer*

A lawsuit filed by a Beverly Hills woman who failed two years ago in an attempt to buy the small hospital chain founded by her father has accused the successful bidder of tampering with her offer. Specifically, she charges that top bankers at New York-based Citibank and Los Angeles-based Security Pacific National Bank were pressured not to lend her the money for the acquisition.

A deposition taken in the case from Citibank Chairman Walter Wriston indicates that a top official of Nashville-based Hospital Corp. of America, the successful bidder, visited Wriston to express "displeasure" about the bank's possible funding of the competing bid.

Los Angeles Times

Toni Brotman Wald

The suit, filed Oct. 29 in U.S. District Court in Los Angeles, as a counterclaim in a previous court action, alleges that Hospital Corp. and others engaged in a conspiracy to prevent Toni Brotman Wald from securing a $142.5-million loan to purchase Culver City-based General Health Services Inc. in 1980.

In addition, Wald, 37, accused Hospital Corp. and its Chairman and Chief Executive Donald NcNaughton of attempting to "coerce and pressure" Security Pacific and Citibank into withdrawing their support for a loan to her newly formed company, Brotman Companies Inc. and its partner, Universal Health Services, a Bala Cynwyd, Pa., hospital management firm.

**Both Board Rooms**

The suit claims that the hospital chain's interference extended to the corporate board rooms of both banks, involving both Wriston and Security Pacific board member Robert Anderson, who is also Chairman of Pittsburgh-based Rockwell International. Anderson is a defendant in Wald's lawsuit, but Wriston is not.

As a result of the pressure, Wald's attorney Arthur Leeds said his client's bid to purchase the hospitals at $38-a-share collapsed. Stockholders voted to accept the $96-million, $32-a-share, takeover offer by Hospital Corp.

"It was just a simple coporate acquisiton," said Donald Fish, Hospital Corp.'s attorney. He said he was not aware of the lawsuit and would not comment on its merits. But in the past, the chain has denied that its conduct may have prevented Wald from obtaining a loan agreement.

At the time of the sale, Hospital

Please see HOSPITAL, Page 2

# HOSPITAL: Coercion Charged in Suit

Continued from First Page

Corp. signed an agreement denying such allegations by Wald and indemnifying the co-executors of her parent's estate from lawsuit if they voted for the takeover. That agreement freed the co-executors to vote for the sale of the hospitals.

Wald's suit was filed as a counterclaim to a suit brought by Universal Health Services against her. In addition to Hospital Corp. and Anderson, the Wald suit also names as defendants Citibank, Security Pacific, Universal Health, and others.

General Health, a chain of seven hospitals across the country, was founded by Wald's father, the late Dr. David M. Brotman. He purchased Culver City Hospital in 1958 and expanded it, and after he died in 1973, it became Brotman Medical Center. General Health also owned Memorial Hospital of Gardena.

Wald was the principal beneficiary of 40% of General Health's stock, but 37% of her shares were controlled by two co-executors—Herman Chanen of Phoenix-based Chanen Construction Co. and Los Angeles-based First Interstate Bank—under a trust and estate set up by her deceased parents. She had voting control over approximately 3% of the shares.

In June, 1980, despite Wald's protests, the two co-executors and General Health's board of directors supported an offer by Hospital Corp. to take over the Culver City firm for $90 million, or $30 a share.

Wald claimed that the offer to purchase General Health was too low and not in the best interest of the shareholders. In October, 1980, she obtained a commitment from Citibank to help finance one-third of the $142.5-million loan, with the remaining two-thirds to be supplied by a syndicate of other financial institutions.

The proceeds of the $142-million loan were to be used to pay $114 million for all the outstanding stock of General Health Services and to provide working capital for the new corporation.

In response to her higher offer, General Health's directors and representatives from Hospital Corp. signed an agreement giving Wald two months to put together the necessary financing. If her syndication failed, she and the two co-executors agreed to vote for Hospital Corp's proposal at $32 a share.

However, Wald claims that while she was negotiating the financing, Hospital Corp. was secretly attempting to thwart her deal.

In his sworn deposition, Citibank's Wriston said McNaughton visited his office to express displeasure with Citibank's decision to finance one-third of the $142.5-million loan. Wriston said that earlier he had received a similar call on Hospital Corp.'s behalf that John deButts, then-chairman of American Telephone and Telegraph.

Wriston's deposition said deButts, who has remained a director of Citibank since retiring as AT&T chairman, telephoned Wriston because he wanted to let him know that he had heard that Hospital Corp. was "unhappy with the bank" because of its decision to help finance Wald's offer. DeButts could not be reached for comment Thursday.

Wriston said in the deposition that, "(McNaughton) informed me that some area of our institution was financing another corporation on some kind of takeover bid, and that he felt that that was something that we should review in view of our long relationship with HCA."

The chairman of Citibank said he told McNaughton that "'we do not take sides in these things, and we were not about to take sides in this one. . . .'"

Pressure, the suit contends, also was placed on Security Pacific loan officers by Anderson, who serves on the board of Hospital Corp. in addition to being a director of the bank.

Anderson could not be reached for comment Thursday, but a spokesman for the executive at Rockwell headquarters in Pittsburgh said Anderson had not yet received the lawsuit and therefore could not respond.

Security Pacific officials deny that the bank succumbed to pressure from Hospital Corp. The Wald loan was turned down on the basis of "financial merit," a spokesman wrote in 1980 when Wald first made the allegations during the General Health shareholders meeting at which the Hospital Corp. acquisition was approved.

However, a confidential memo by a Citibank executive, who worked closely with the financing, disagreed. The memo is filed as part of Wald's lawsuit.

"Our efforts to achieve adequate syndication failed largely from the active efforts by HCA to squash the $142.5-million financing by contacting potential syndicate banks and pressuring at senior levels not to go along with the deal," wrote Theodore Widmayer, a vice president.

"In fact, I was told by a counterpart at Security Pacific that HCA pressured their seniors in the Los Angeles headquarters to decline participation at the eleventh hour," he added. "This was after Security had given us very strong indications of a $25-million to 30-million participation. Their withdrawal was the key in not accomplishing the required syndication."

Wald's suit contends that less-than a week before the close of her December deadline she was informed by Citibank that it was having problems raising the money.

After the syndication collapsed, Wald accused Hospital Corp. of breaching its agreement allowing her to search for financial backing of the loan, and she requested more time to find additional backers. She was turned down.

Hospital Corp. which denied the allegations, then signed the agreement to indemnify co-executors in case of a lawsuit. The shareholders signed the agreement and voted to sell the hospital.